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VERA

VETERANS EQUITABLE RESOURCE ALLOCATION

VERA 10 High Cost Patients and Capping

BASIC CARE COMPLEX CARE RESEARCH EDUCATION EQUIPMENT NRM GEOGRAPHIC PRICE ADJUSTMENT

Equity of Funding and Access to Care Across Networks

Department of Veterans Affairs

2003

Veterans Equitable Resource Allocation System

Seventh Edition

March 2003

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration

Washington DC 20420

Foreword

The Veterans Health Administration (VHA) instituted the Veterans Equitable Resource Allocation (VERA) system in April 1997 to allocate funds to networks. VERA ensures that the allocation of funds is equitably distributed based on veterans who use the VA health care system rather than simply being based on historic funding patterns. The implementation of VERA has been part of a larger plan to transform VA's health care system from individual medical centers and clinics focused primarily on inpatient care to a fully integrated system with expanded primary and ambulatory care capability. VERA has been, and will continue to be a critical component of VA's success in implementing the mission and vision of the VHA.

The VERA system pays each network a "tailored" price that reflects the unique characteristics of each network. For example, network funding is based on a combination of patient workload, adjustments for regional variances in labor and contract costs, high cost patients, research support, education support and equipment and non-recurring maintenance. While VERA has significantly improved the allocation of the $23.9 billion of the veterans' health care budget, the VHA will continue to review and examine the model to assure its continued relevance and to identify needed improvements.

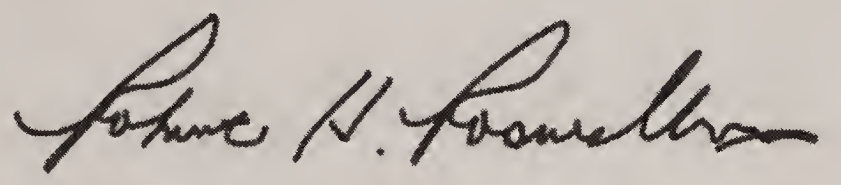
Since VERA was introduced in 1997, there have been the following eight assessments of VERA: GAO (1997, 1998, and 2002), PricewaterhouseCoopers LLP (1998), AMA Systems (April and July 2000), and the RAND Corporation (Phase I in 2001 and Phase II in 2002). These independent reviews have validated the VERA methodology as meeting its objectives and the original intent of Congress under Public Law 104-204. As described in this VERA Book, based on study findings and recommendations from these eight assessments, VERA refinements were made or, in the case of the recent studies (GAO audit completed in February 2002 and the RAND Phase II study completed on October 4, 2002), recommendations are in the process of being evaluated. The process for refining the VERA methodology can be internally generated by VA users of the VERA system or externally generated by outside VERA evaluators. The VERA refinements generated by the internal and external groups are reviewed and

recommended by the VHA National Leadership Board (NLB), and then provided for my action and the Secretary's approval.

For FY 2003, three resource allocation changes have been made to the VERA methodology. One change provides an additional allocation to networks for the top 1% high cost patients whose annual costs exceed an established threshold of $70,000. Networks will receive an additional allocation equal to the amount that these costs exceeded the threshold. The second change expands the case-mix adjustment from a three price case-mix model to a ten price case-mix model. The third change ensures that networks will receive a minimum increase of five percent and a maximum increase of 12.6 percent over their final FY 2002 allocation.

This VERA Book is the seventh edition and updates the March 2002 sixth edition. It contains the VERA allocations for FY 2003, as well as a discussion of the changes to the methodology approved in FY 2003, proposals for changes not approved in FY 2003 and potential changes being considered for future years.

With the modifications for FY 2003 that will continue into FY 2004, and the ongoing evaluation of the VERA model for FY 2005 and beyond, VHA will ensure that the allocation of taxpayer dollars for veterans' health care remains fair, equitable, and effective.



Robert H. Roswell, M.D.
Under Secretary for Health

EXECUTIVE SUMMARY

Background

In April 1997, VA implemented VERA to allocate comparable resources for comparable workloads in its health care networks to ensure equitable access to care for the Nation's veterans. Supplemental funding adjustments and local health care reimbursements and collections provide additional sources of funds to each network. VA stresses the expectation that networks must continue to become as efficient as possible – while maintaining or improving the quality of care and services provided to all veterans who seek care. Experience has shown that networks continue to provide quality care and expand services to veterans, while VERA has improved the fairness of the allocation system.

Over the past several years, VERA has undergone extensive internal and external scrutiny to assess whether the methodology is meeting its goal of equitable and effective resource allocation. A PricewaterhouseCoopers LLP study (1998) and three government-sponsored General Accounting Office (GAO) assessments (1997, 1998, and 2002) viewed the progression of VERA in decidedly positive terms. In February 2002, GAO issued its third congressionally mandated assessment of VERA, entitled *VA Health Care: Allocation Changes Would Better Align Resources with Workload.* The RAND Corporation completed a Phase I review of VERA in September 2001, and submitted its Phase II congressionally mandated VERA report to VA on October 4, 2002. VA provided the RAND Phase II report to Congress on November 5, 2002. Both GAO and RAND provided commentary and recommendations to enhance the VERA methodology's effectiveness. VHA is addressing these recommendations for ongoing and future VERA refinements.

VERA is a progressive resource allocation methodology, and has undergone several technical adjustments since its inception. For FY 2003, three significant changes have been made to VERA and they are described in the sections that follow, along with the changes to the national average prices per patient.

VERA Changes

Based on the work generated by internal VA users of the VERA system and external VERA evaluations, the Secretary approved the following changes in VERA for FY 2003. The rationale for these refinements is to:

- Improve equity of the allocation process and decisions.

- Be responsive to the GAO and the RAND recommendations.
- Recognize price and cost differences in "core mission" patients (those veterans with service-connected disabilities or those with incomes below the current income threshold or special needs patients, e.g., the homeless).
- Require minimal education for VERA users.
- Eliminate need to provide networks with supplemental funding adjustments.
- Provide a disincentive for unaffordable workload growth.

Additional Allocation for Top 1% High-Cost Patients – This change provides an additional allocation to networks with the highest cost patients by recognizing the impact on those networks with patients whose annual costs exceed $70,000. These networks will receive an additional allocation equal to the amount that these costs exceeded $70,000. This addresses not only the highest cost Complex Care patients, but also those in the Basic Care group.

Ten VERA Price Groups – This change expands the VERA price groups from three to ten and recognizes a differentiation in VA's "core mission" patients (veterans with service-connected disabilities or those with incomes below the current threshold or special needs patients, e.g., the homeless) not present in the previous three VERA patient groups. It follows the recommendation provided in the GAO and RAND reports and improves allocation equity among the 21 networks. This change also modifies the funding allocation split between Basic Care and Complex Care to reflect the current cost experience between these groups rather than using a fixed ratio that reflects their FY 1995 relative costs.

FY 2003 National Average Prices Per Patient – The ten price groups for FY 2003 are: Non-Reliant – $263, Basic Medical – $2,413, Mental Health – $3,562, Heart, Lung and Gastrointestinal – $3,722, Oncology – $8,337, Multiple Problem – $7,935, Specialized Care – $18,751, Supportive Care – $29,780, Chronic Mental Illness – $39,448 and Critically Ill – $61,117.

Minimum 5% Increase and Maximum 12.6% Increase – This change provides that networks will receive a minimum five percent allocation increase above the final amount received in FY 2002 (includes: initial FY 2002 allocation, an additional $162 million from Specific Purpose Funds, $6.8 million World Trade Center Funding adjustment to Network 3, $142 million supplemental appropriation funding, and $82.4 million from the National Reserve Fund, which includes $17.4 million for Network 1's operational shortfall). In order to pay for the increases so that any network that would be receiving less than a five percent increase above the final amount received in FY 2002 would be increased to five percent, VA has instituted a ceiling on fast-growing networks. Funding increases for all the networks will be capped at 12.6 percent over the final amount received

in FY 2002. This high cap is expected to discourage unmanaged workload growth.

Research Support – In FY 2003, networks will again pass research support funds through to each medical center and the medical centers will obligate funds to support the salaries of clinician-researchers and other research related expenses. Prior to FY 2000, the national funding level for research support was allocated to the networks. Network management in the context of network-wide operations determined the actual level of support expenditures. During FY 2001, VA Beta Tested a new research support accounting methodology at 29 VA medical centers to document research support costs differently than recorded in the Cost Distribution (CDR) Report. As a result of this Beta Test, action was taken during FY 2002 to expand the testing of this new research support accounting methodology to all VA medical centers with research programs, and to subsequently integrate this new accounting methodology into the Decision Support System (DSS).

VERA Changes Not Approved

There was one additional change recommended for FY 2003 implementation that the Under Secretary for Health did not approve. This was to include Basic Care Priority 7 veterans not previously included in the VERA methodology. In recent years, this group of patients has grown significantly even though they were not included in VERA Basic Care. It was feared that the inclusion of these patients in the VERA methodology would provide added incentives to increase the number of these patients. If that did occur it would mean there would be less of VHA's appropriated budget for its "core mission" patients.

FY 2003 VERA Results

The following table shows the composition of FY 2003 VERA results by network.

Results of VERA Model - FY 2003

($ in millions)

Network	Basic and Complex Care Workload with Geographic Price Adjustment*	High Cost Patient Funding	Research Support	Education Support	Equipment	NRM	5% Capping	Total
1 Boston	$838	$82	$33	$21	$26	$13	$0	$1,012
2 Albany	$481	$38	$4	$10	$16	$8	$0	$556
3 Bronx	$845	$152	$12	$24	$24	$16	$38	$1,112
4 Pittsburgh	$936	$71	$15	$13	$32	$16	-$6	$1,077
5 Baltimore	$516	$51	$19	$10	$15	$7	$0	$618
6 Durham	$858	$67	$13	$15	$28	$9	$0	$991
7 Atlanta	$997	$79	$19	$18	$34	$12	$0	$1,159
8 Bay Pines	$1,502	$80	$13	$23	$52	$19	-$33	$1,656
9 Nashville	$812	$40	$14	$22	$28	$11	$0	$927
10 Cincinnati	$666	$51	$13	$11	$21	$10	$0	$771
11 Ann Arbor	$718	$66	$17	$13	$24	$12	$0	$849
12 Chicago	$806	$89	$21	$26	$23	$12	$0	$978
15 Kansas City	$677	$32	$5	$13	$23	$11	$0	$761
16 Jackson	$1,483	$88	$20	$28	$52	$18	-$1	$1,689
17 Dallas	$816	$54	$16	$14	$28	$10	$0	$937
18 Phoenix	$713	$33	$9	$13	$26	$10	$0	$803
19 Denver	$459	$30	$8	$9	$16	$6	$0	$528
20 Portland	$772	$58	$23	$11	$26	$13	$0	$903
21 San Francisco	$862	$92	$51	$16	$26	$15	$0	$1,062
22 Long Beach	$1,006	$97	$50	$30	$32	$17	-$12	$1,220
23 Minneapolis	$781	$45	$25	$16	$26	$11	$13	$918
VHA Total	$17,542	$1,395	$400	$356	$578	$255	$0	$20,526

Note: The numbers may not add due to rounding.

*This includes $15.3 billion for special programs, see Appendix 1.

When estimated MCCF (Medical Care Collections Fund) collections, Health Services Improvement Fund and estimated reimbursements (including TRICARE and sharing) are added to the FY 2003 VERA allocations, the largest percentage increase from FY 2002 in funds available for any network is 15.11%, while the smallest percentage increase in total funding for any network is 6.68%, as shown in the following table. This table shows historical VERA allocations with adjustments and estimated receipts for FY 1996 to FY 2003.

FY 1996 - FY 2003 VERA Allocations with Adjustments and Estimated Receipts

($ in millions)

Network	FY 1996 Allocations and Receipts	FY 1997 VERA and Receipts	FY 1998 VERA and Receipts	FY 1999 VERA and Receipts	FY 2000 VERA and Receipts	FY 2001 VERA and Receipts	FY 2002 VERA and Receipts	FY 2003 VERA and Receipts	% Change FY 1996-1997	FY 1997-1998	FY 1998-1999	FY 1999-2000	FY 2000-2001	FY 2001-2002	FY 2002-2003	FY 1996-2003
1 Boston	$856	$848	$854	$821	$853	$936	$1,006	$1,092	-1.02	0.78	-3.89	3.91	9.72	7.45	8.57	27.52
2 Albany	$438	$435	$441	$431	$478	$516	$536	$599	-0.68	1.32	-2.12	10.81	7.94	3.95	11.67	36.76
3 Bronx	$1,024	$1,019	$1,021	$994	$1,010	$1,038	$1,121	$1,200	-0.48	0.16	-2.61	1.57	2.84	8.00	7.00	17.19
4 Pittsburgh	$776	$781	$819	$828	$901	$988	$1,028	$1,177	0.53	4.85	1.21	8.72	9.71	4.00	14.58	51.64
5 Baltimore	$426	$444	$484	$489	$527	$575	$605	$661	4.21	9.00	1.15	7.74	9.17	5.18	9.19	55.18
6 Durham	$687	$713	$749	$754	$828	$893	$951	$1,092	3.68	5.12	0.67	9.77	7.88	6.43	14.86	58.86
7 Atlanta	$781	$816	$896	$922	$983	$1,057	$1,140	$1,248	4.54	9.83	2.88	6.62	7.49	7.88	9.47	59.87
8 Bay Pines	$962	$1,021	$1,113	$1,161	$1,339	$1,427	$1,583	$1,822	6.06	9.03	4.34	15.34	6.56	10.90	15.11	89.31
9 Nashville	$691	$703	$741	$746	$811	$857	$925	$1,014	1.76	5.37	0.69	8.74	5.58	7.95	9.65	46.72
10 Cincinnati	$513	$533	$558	$574	$639	$682	$736	$819	3.86	4.78	2.95	11.32	6.66	7.94	11.30	59.82
11 Ann Arbor	$656	$659	$665	$687	$726	$794	$828	$931	0.39	0.97	3.36	5.58	9.38	4.33	12.43	41.92
12 Chicago	$839	$832	$840	$820	$868	$928	$973	$1,063	-0.78	0.91	-2.38	5.87	6.95	4.80	9.27	26.74
15 Kansas City	$587	$618	$645	$635	$669	$717	$779	$836	5.25	4.41	-1.56	5.36	7.23	8.69	7.23	42.43
16 Jackson	$1,077	$1,139	$1,245	$1,283	$1,434	$1,497	$1,596	$1,821	5.76	9.30	3.08	11.73	4.39	6.63	14.13	69.13
17 Dallas	$592	$630	$688	$687	$774	$831	$907	$1,014	6.32	9.17	-0.13	12.72	7.39	9.17	11.70	71.12
18 Phoenix	$495	$528	$579	$597	$715	$752	$784	$874	6.58	9.67	3.16	19.64	5.25	4.26	11.51	76.52
19 Denver	$368	$386	$412	$407	$449	$488	$528	$580	4.82	6.79	-1.27	10.28	8.70	8.32	9.87	57.68
20 Portland	$589	$626	$681	$704	$789	$834	$889	$971	6.38	8.64	3.51	11.95	5.73	6.63	9.25	64.94
21 San Francisco	$690	$724	$755	$773	$850	$929	$995	$1,122	4.93	4.29	2.29	10.00	9.35	7.06	12.77	62.56
22 Long Beach	$903	$921	$966	$957	$1,000	$1,076	$1,131	$1,275	2.00	4.88	-0.95	4.51	7.60	5.08	12.75	41.17
23 Minneapolis	$713	$718	$736	$756	$798	$911	$966	$1,031	0.67	2.59	2.65	5.55	14.18	6.05	6.68	44.56
VHA Totals	$14,664	$15,092	$15,886	$16,028	$17,439	$18,726	$20,008	$22,243	2.92	5.27	0.89	8.81	7.38	6.84	11.17	51.68

Note: The FY 1998 MCCF totals include FY 1997 4th quarter collections. The FY 2003 MCCF and Reimbursement figures represent projected collections. The numbers may not add due to rounding.
FY 1999 Includes VERA plus $20M earmarked by the Congressional Appropriations Conference Committee for Network 3. FY 1999 includes VERA plus adjustments for newly decentralized programs for networks which exceed the 5% limitation. FY 1998, FY 1999, FY 2000 and FY 2001 include supplemental funding adjustments. FY 2000 figures have been adjusted to reflect the centralized funding of Prosthetics for FY 2001. FY 2002 includes the VERA adjustments for 4 networks. FY 2001 figures have also been adjusted to reflect the rescission ($43M).

Assessments of VERA

VERA has been in operation for five and one-half years and has been subjected to eight assessments. Of these, one was conducted by PricewaterhouseCoopers LLP, the second and third were conducted by AMA Systems, Inc., the fourth and fifth were completed by the U.S. General Accounting Office (GAO), and the sixth, seventh, and eighth reviews were conducted by the RAND Corporation (Phase I and Phase II) and the GAO for a follow-up audit. The most recent GAO and RAND studies are discussed in this section. The other assessments are discussed in Appendix 3.

General Accounting Office Findings and Recommendations

Early in FY 2001, Congress asked GAO to study the VERA methodology and answer the following questions:

- Has implementation of the VERA methodology resulted in a more equitable allocation of VA health care resources?
- What specific problems are VISNs and medical facilities experiencing with the VERA methodology?

On February 28, 2002, GAO issued a report entitled *VA Health Care: Allocation Changes Would Better Align Resources with Workload (GAO-02-338).* GAO concluded that VERA is a reasonable approach to allocate resources, but identified weaknesses in its implementation. GAO recommended that VA correct these weaknesses to better allocate comparable resources for comparable workloads.

The five GAO recommendations are as follows:

1. Better align VERA measures of workload with actual workload served regardless of veteran priority group.
2. Incorporate more categories into VERA's case-mix adjustment.
3. Update VERA's case-mix weights using the best available data on clinical appropriateness and efficiency.
4. Determine in the supplemental funding process the extent to which different factors cause networks to need supplemental resources and take action to address limitations in VERA or other factors that may cause budget shortfalls.
5. Establish a mechanism in the National Reserve Fund to partially offset the cost of networks' highest cost Complex Care patients.

VA concurred with GAO's recommendations and has addressed VERA case-mix and risk adjustment changes, among others. Some of the issues and actions involved with VA's addressing these recommendations are:

- Although inclusion of non-service-connected Priority 7 veterans in the VERA Basic Care category would be a step toward better aligning the VERA allocation model with VA's actual enrollment experience, including these veterans in the VERA model would create financial incentives to seek out more of these veterans instead of veterans with service connected disabilities or those with incomes below the current income threshold or special needs patients (e.g., the homeless), veterans who comprise VA's core health care mission. Therefore, the Secretary decided not to include non-service-connected Priority 7 veterans in the VERA Basic Care category.
- VA identified and evaluated three potential case-mix approaches. The three potential approaches were:
    1. VERA with 47 case-mix categories, (GAO used 44 classes in its report based on FY 2001, in FY 2003 there are 47 classes)
    2. VERA with 10 case-mix categories, which is a higher grouping of the 47 case-mix categories; and
    3. The Diagnostic Cost Groups (DCGs) with 25 case-mix categories (only 24 cost groups).
- The Secretary made a decision to implement the VERA-10 case-mix methodology in FY 2003. This includes 6 Basic Care price groups and 4 Complex Care price groups.

- By implementing the VERA-10 case-mix price groups in FY 2003, there is no longer a need to maintain the FY 1995 Complex Care/Basic Care artificial allocation split of 38% Complex and 62% Basic. This change updates the FY 1995 weights to reflect the current base year experience. It is not anticipated that this change will create a disincentive for the enrollment and treatment of Complex Care patients.
- VA implemented caps on the FY 2003 VERA allocation increase over adjusted FY 2002 allocations at the low end of + 5% and at the high end of +12.6%. As a result, it is expected there will be no supplemental VERA adjustment in FY 2003.
- For FY 2003, VA provided an allocation for each network's top 1% high-cost patients. This change recognizes the impact of high-cost patients whose annual costs exceed an established threshold of $70,000. Networks receive an additional allocation equal to the amount that their patient's costs exceed the $70,000 threshold.

The RAND Corporation Study – An Analysis of the Veterans Equitable Resource Allocation (VERA) System – Phase I and Phase II.

Congress directed in Public Law 106-377 that VA enter into a contract with a federally-funded research and development center to conduct an analysis of VERA. VA contracted with the RAND Corporation to conduct this study. In July 2001, RAND submitted its Phase I VERA report to the VHA Office of Finance. In turn, on September 18, 2001, VA transmitted the Phase I VERA report to Congress.

The FY 2002 Senate Appropriations Committee report language indicated the Committee was pleased with the initial results of the VERA study and directed VA to continue this federally-funded research and development center study through the end of FY 2002. The RAND Corporation submitted its Phase II VERA report, "An Analysis of Potential Adjustments to the Veterans Equitable Resource Allocation (VERA) System", to VA on October 4, 2002. It was provided to Congress on November 5, 2002. The FY 2003 Senate Appropriations Committee report language further directed VA to continue this federally-funded research and development center study through the end of FY 2003.

The purpose of the RAND VERA study was to determine whether VERA's methodology leads to a distribution of funds that covers the special needs of some veterans and investigate the progress of this funding allocation method. Congress expressed the following three specific areas of concern for the study.

- The impact of the allocation of funds under the VERA formula on VISNs and sub-regions with older-than-average medical facilities; those with older or

more disabled enrolled veterans; those undergoing major consolidation; and/or those with appointment backlogs and waiting periods in rural and urban sub-regions.
- Issues associated with the maintenance of direct affiliations between VA medical centers and university teaching and research hospitals.
- Whether the VERA formula for allocating funds adequately accounts for differences in weather conditions when calculating the cost of construction and maintenance of health care facilities, and whether VISNs that experience harsh weather conditions require more resources.

To address these issues within the project's allotted time frame, RAND initially conducted a qualitative analysis of the VERA system gathering data from site visits, interviews, and published reports. Findings from that analysis appear in a report entitled "An Analysis of the Veterans Equitable Resource Allocation (VERA) System" (RAND MR-1419-DVA).

The Phase I report identified several key issues that would require additional quantitative evaluation to resolve; however, such analysis was outside the scope of that initial phase of work. As a result, in the fall of 2001, Congress directed VA to continue the federally-funded research and development center study through FY 2002. VA contracted with RAND to conduct a Phase II VERA study.

An underlying concern in Phase I, and one that was articulated in the legislation calling for the study, was whether the VERA system for allocating resources omitted consideration of certain factors, particularly factors that had a predictable and systematic impact on the costs of providing health care to veterans and were largely outside the control of VISN directors. The goal of the Phase II VERA study was intended to evaluate the impact of these factors on the variation in individual patient costs across VISNs and to assess the potential effects of modifications that might be made to VERA for such factors.

A brief summary of the contractor's findings and conclusions follow, which address both the Phase I VERA and Phase II VERA study task requirements.

Phase I VERA Report Overview:

- Overall, the study identified factors that may influence the costs of, and access to, care within the VA system and assessed how VERA adjusts for those effects. Among the findings of the report was that health care delivery costs might be affected by the age, physical condition, and historical significance of a VISN's facilities, factors for which VERA makes no adjustments.
- Another finding was that VERA's case-mix adjustment methodology might not account adequately for differences in the average health status of veterans

across VISNs. In contrast, the influence of such factors as weather extremes and rural versus urban location appeared less clear. Finally, the report concluded that a comprehensive evaluation of the current system, as well as the potential effects of modifications to it, would require extensive, quantitative analysis.

For Phase II, RAND analyzed data from a variety of sources including VA, the Centers for Medicare and Medicaid Services, and individual counties nationwide, and evaluated the effects of 17 patient-specific and 22 facility-specific characteristics on the variation in individual patient costs across VISNs.

The major findings are summarized as follows:

- For the most part, facility infrastructure characteristics do not play an important role in explaining patient cost variation.
- Additional adjustments to VERA may be warranted:
    - VERA-10 or VA Diagnostic Cost Groups (DCGs) should be used to adjust for case-mix differences.
    - If more refined case-mix adjustment is made, educational support should be revisited.
    - Medicare reliance should be accounted for.
- To make these adjustments, VA should consider adopting an allocation system that relies on a regression/simulation framework similar to the one used in the Phase II analysis. However, before making any modifications along these lines, during Phase III of the study, VA should:
    - Examine why gainers and losers are different under VERA-10 and VA DCGs.
    - Disaggregate simulated allocations to better understand impact of different variables.
    - Update the models using FY 2001 VA data and FY 2000 Medicare data.
- Modeling approach may be used in the adjustment process and in making network to facility allocations.

The FY 2003 Senate Appropriations Committee report language has directed a Phase III RAND VERA study that will provide analyses analogous to the ones in Phase II, using the most recent VA and Medicare data. Further, in Phase III, RAND will provide the results of disaggregating the data to allow the examination of VISN allocations by selected patient and facility level variables. The Senate Appropriations Committee directed VA to provide interim reports on Phase III in February 2003 and June 2003 and a complete study by the end of FY 2003.

Potential Future Changes to VERA

In the interest of continuous improvement, studies are ongoing to ensure that the VERA methodology includes timely and accurate information and processes.

Patient Classifications – In addition to the VERA-10 methodology, VHA is currently reviewing two other methodologies for potential application in the FY 2005 network budget allocations. The RAND Corporation Phase II VERA Report indicated that VA should consider modifying VERA to a regression based model that would include 21 patient and facility variables compared to VA's current VERA-10 model. However, RAND noted that before moving to a regression based model Phase III of its study should be completed in order to:

- Examine how the variables influence allocations.
- Refine the model to reflect more recent data.
- Resolve key implementation issues.
- Make the model more transparent to users.

During FY 2003, the National Leadership Board (NLB) Finance Committee will continue to review future VERA methodology changes, e.g., Diagnostic Cost Groups (DCGs), for potential application in FY 2005. Over the past several years, the use of DCGs and risk adjusters have been studied by the VHA Houston Center for Quality of Care and Utilization Studies, a VA Health Services Research and Development (HSR&D) Center for Excellence and the VHA Management Science Group in Bedford, Massachusetts, currently for the NLB Finance Committee and previously the VERA Patient Classification Workgroup. The VA-DCG model is similar to the one used by the Centers for Medicare and Medicaid Services (CMS) for its Medicare + Choice program and is a case-mix model that is based mainly on diagnosis and demographics of patients, except in the case of special needs Complex Care patients, where case-mix is based on utilization factors similar to the VERA model. In the DCG model, ICD-9-CM Diagnostic Codes are used to produce 545 diagnostic groups that are further classified into 118 Hierarchical Condition Categories (HCCs). For allocation purposes, patients are then grouped based on their predicted expenditures into Diagnostic Cost Groups. The DCGs for VA purposes contain 25 case-mix categories (only 24 cost groups). The Houston Center for Quality of Care and Utilization Studies and the Management Science Group have developed modifications to the current DCG system using actual VA cost data. If the NLB Finance Committee review demonstrates identifiable benefits, a DCG or modified DCG system could be considered for the FY 2005 allocation process.

TABLE OF CONTENTS

Page

Executive Summary i

Sections

I. VERA Components 1
II. VERA Results 24
III. Assessments of VERA 41
IV. The Future of VERA 52

Appendices:

Appendix 1: Key formulas and data in the FY 2002 VERA 54
Appendix 2: The Veterans Integrated Service Networks 86
Appendix 3: History: Previous Allocation Models, Changes to VERA, Results, VERA Supplemental Adjustments and Previous Assessments 89

Listing of Figures and Tables

Figure 1: General Purpose and Specific Purpose components of VERA 3
Figure 2: Establishing VERA national prices, FY 2003 10
Figure 3: FY 2003 VERA geographic price adjustment 15
Figure 4: Components of Specific Purpose VERA funding 21
Figure 5: Projected VERA average price by network FY 2003 28
Figure 6: Impact of VERA model 33
Figure 7: Percent change in allocation in each VERA component, FY 1997 to FY 2003 35
Figure 8: FY 1996 – FY 2001 dollars spent per patient, percent variance from national average 37
Figure 9: Historic resource consumption per patient 92
Figure 10: Basic single outpatient visits as percent of 3-year Basic workload, by network, FY 1995 – FY 1997 96
Figure 11: Basic single outpatient visits and non-vested workload as percent of 3-year Basic workload, by network, FY 1996 – FY 1998 97
Figure 12: Non-vested workload as percent of 3-year Basic workload, by network ... 98

Table 1: Composition of VERA-10 price groups 7
Table 2: Basic and Complex Care workload FY 2003 8
Table 3: Network Basic Care and Complex Care allocations FY 2003 11
Table 4: VERA ten price group case-mix 12
Table 5: Geographic price adjustment 14
Table 6: Research support allocation 17
Table 7: Education support allocation 18

Table 8: Equipment allocation 19
Table 9: Non-Recurring Maintenance allocation 20
Table 10: Results of VERA model – FY 2003 24
Table 11: Changes in network budgets FY 2002 – FY 2003 25
Table 12: FY 2003 VERA outcome without 5% low cap 26
Table 13: Change in network allocations over prior year including VERA adjustments 31
Table 14: Network allocations compared to system-wide increase over prior year including VERA adjustments 31
Table 15: FY 1996 – FY 2003 resource allocations by network (capped and with VERA adjustments) 32
Table 16: Percent change in allocation in each VERA component, FY 1997 to FY 2003 34
Table 17: MCCF and other collections – FY 2003 38
Table 18: FY 1996 – FY 2003 VERA allocations with adjustments and estimated receipts 40
Table 19: VERA adjustments FY 1999 – FY 2002 105

Section I
VERA Components

To simplify VA's funding allocation system and to make it understandable and credible, the easiest approach would have been to implement a system that simply measured the number of veterans who use VA health care, and then give to each network a single dollar amount for each veteran in that network. This was believed to be unworkable because of the varying health care needs of VA's patients and the complexity of the VA health care system. These complexities must be recognized and balanced with the need for an equitable and understandable funding allocation system.

VERA addresses the complexities of veterans' health care by recognizing several factors, including:

- ***VA treats three general types of patients*** – those who use some health care services but are less reliant on the VA system, those with "routine" health care needs who rely on VA health care, and those with "special" or "complex," and generally chronic, health care needs that are relatively expensive;

- ***VA patients are identified in one of 47 patient classes*** which are further aggregated into ten case-mix price groups;

- ***Two types of funds*** – The medical care appropriation is divided into general purpose funds allocated based on patients treated and specific purpose funds allocated on other basis because of special legal or programmatic requirements, national support functions, and projects where economies of scale can be achieved at a national level support the continuation of some allocations outside the VERA model;

- ***The costs of providing care across the country varies*** because of factors that are beyond the control of VA management (e.g., the cost of labor and contracts in New York is higher than in Mississippi);

- ***Not all veterans receive their VA health care in the same network***. Many veterans receive care in more than one network. For example, veterans commonly referred to as "snowbirds" live in the northeast part of the year and in the south or southwest the remainder of the year;

- ***Costs for Research and Education vary*** because of differences across the country in VA's academic affiliations and research programs;

- ***Equipment and Non-Recurring Maintenance investments vary*** because of cost-of-living differences across networks and prior year investments.

Each of these complexities is addressed in the VERA system and is explained in detail in the following sections.

VHA's medical care appropriation is divided into two major components: (1) General Purpose funding and (2) Specific Purpose funding. For FY 2003, General Purpose funds will constitute 86% ($20.53 billion) of VA's Medical Care budget and is distributed to the 21 networks using the VERA model. The Specific Purpose portion will constitute the remaining 14% ($3.37 billion) and is allocated outside the VERA model.

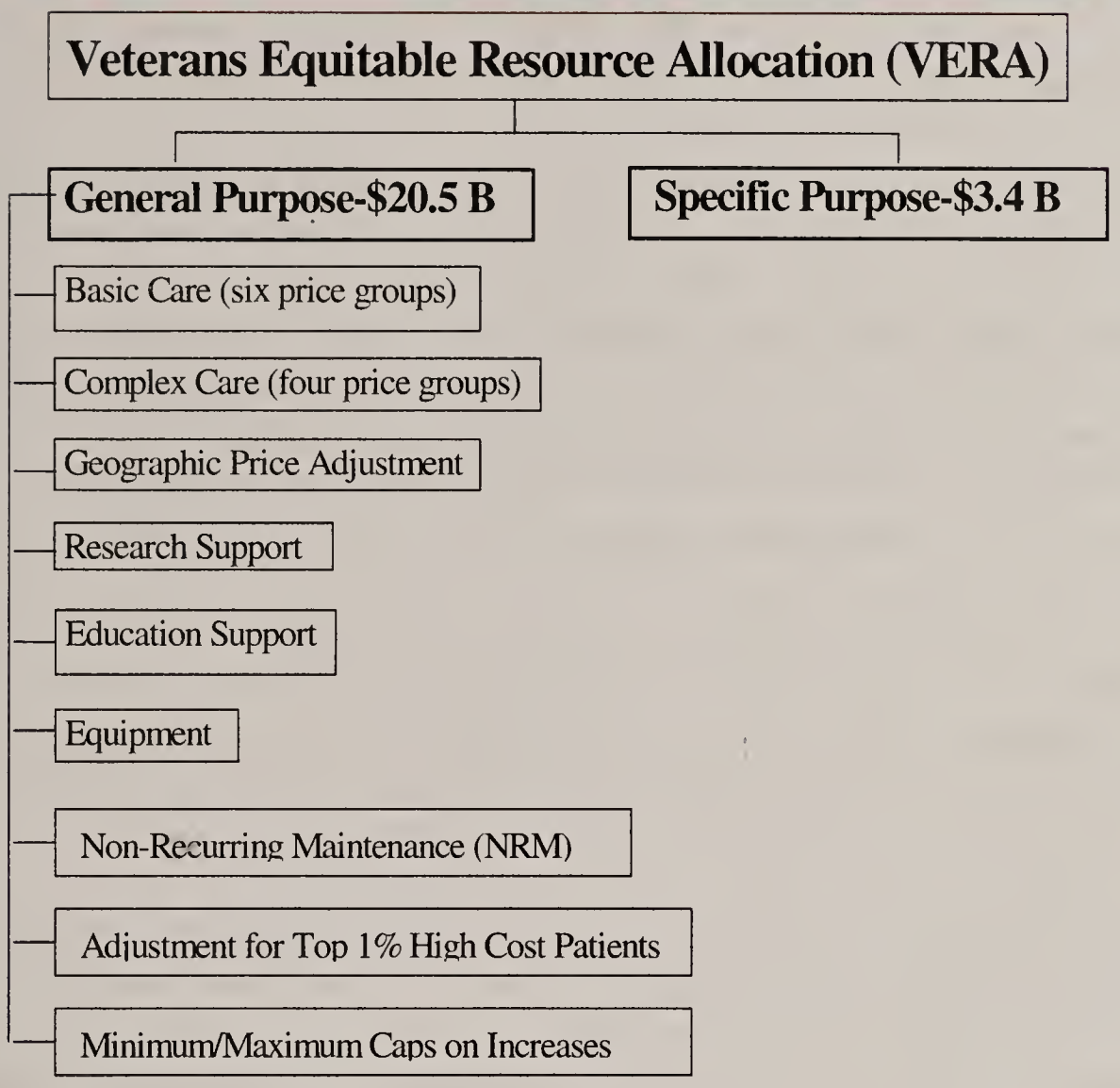
General Purpose Funds

To recognize the complexities discussed above, VERA consists of nine elements used to allocate General Purpose funds. These are:

1. Basic Care (with six price groups)
2. Complex Care (with four price groups)
3. Geographic Price Adjustment
4. Research Support
5. Education Support
6. Equipment
7. Non Recurring Maintenance (NRM)
8. Adjustment for top 1% high cost patients
9. Minimum/Maximum caps on FY 2003 allocation increases

Figure 1 (in billions of dollars) depicts the VERA system and the dollar amounts in General Purpose and Specific Purpose funds.

Figure 1: General Purpose and Specific Purpose Components of VERA



The nine General Purpose elements were developed to balance recognition of the complexities of the VA health care system with the need to make the funding allocation process more understandable and fair. Each of the nine factors is discussed in the following sections.

Workload Elements: Basic and Complex Care

Funding the Basic and Complex Care elements accounts for the overwhelming majority of the Medical Care appropriation -- $18.9 billion (79%). These two elements allocate funding based on the patient workload that the networks are expected to provide in FY 2003.

There are three fundamental components underlying each of the Basic and Complex Care elements:

1. Patient Groups (types of patients)
2. Workload (volume of patients within patient groups)

3. Price Setting (dollar value of workload volume within patient groups)

Each of these three components is discussed below.

Patient Groups

Basic Care patients are those who have relatively "routine" health care needs. They are principally cared for in an ambulatory care setting with short-term inpatient admissions, as needed. They generally do not require the services of the special emphasis programs such as spinal cord injury, blind rehabilitation, and chronic mental illness. They have a range of health care needs from simple to complex, including conditions such as acute and chronic cardiovascular disease, cancer, diabetes, acute substance abuse disorders, acute mental disorders and a broad range of primary care needs. Ninety-six percent of VA's patients receive Basic Care. These patients represent 67% of the dollars allocated through the Basic and Complex Care elements of VERA before high cost adjustment. In FY 1999, Basic Care was further divided, and a separate price established, to address those patients who had only one outpatient encounter during the 3-year workload period. These veterans had very little reliance on the VA health care system.

Differences between the vested (Basic Vested) patient and the occasional user (Basic Non-Vested) was further refined for the FY 2000 network budget allocations. VA's goal was to determine what constitutes a vested patient, even with one visit, and fund those patients at the full Basic Care price. VA decided that clinical measurement criteria would be established as the basis for all patient classes and to move away from basing classifications on counting visits and hospital stays. A description was needed for the limited user that was not based on the number of care encounters (clinic visits or hospital stays). As a result, beginning in FY 2000, Basic Care patients consist of two groups; vested, those who rely on VA for their care, and non-vested, those who use some VA health care services but are less reliant on the VA system. A patient is considered vested in the veterans' health care system if he or she has used inpatient services or if he or she received an appropriate, detailed medical evaluation during the past three years. This medical evaluation is determined through the presence of an appropriate Current Procedural Terminology (CPT) code. By applying relevant CPT codes to outpatients seen in Fiscal Years 1999, 2000, and 2001, and counting the inpatients for those same years, patients identified for the FY 2003 VERA as either vested or non-vested and are classified into 21 of the 47 patient classification groups. These 21 classes are then aggregated to one of six Basic Care price groups as shown in Table 1 on page 7.

Complex Care patients are those that generally require the services of VA's special emphasis programs. These patients have had, or will require, significant high-cost inpatient care as an integral part of their rehabilitation or functional maintenance. These patients include those with hepatitis C with anti-viral therapy, spinal cord injury, chronic mental illness, stroke, traumatic brain injury, post-traumatic stress disorder (PTSD), ventilator dependency and those who need extended care, blind rehabilitation, organ transplants, dialysis, as well as HIV/AIDs veterans with infection or malignancy and who are on specific HIV medications. The Complex Care group accounts for only 4% of the users, but 33% of the dollars available for the Basic and Complex Care groups. Based on the Complex Care patients seen in Fiscal Years 1997, 1998, 1999, 2000, and 2001 a forecast of FY 2003 Complex Care patients is made. These patients are classified into 26 of the 47 patient classes. These 26 classes are further aggregated into the four Complex Care price groups shown in Table 1 on page 7.

Ten VERA Price Groups: The VERA price groups were expanded from three to ten in FY 2003 to recognize a differentiation in VA's "core mission" patients (veterans with service-connected disabilities or those with incomes below the current threshold or special needs patients, e.g., the homeless) not present in the previous three VERA price groups. This change is consistent with the recommendations in the GAO and RAND reports and improves equity of resource allocation among networks. This change also modifies the initial funding allocation split between Basic Care and Complex Care to reflect the current base year cost experience rather than continuing to use the fixed FY 1995 cost split ratio.

Additional Allocation for the Top 1% High-Cost Patients: This change provides an additional allocation to networks with the highest cost patients by recognizing the impact on those networks with patients whose annual costs exceed $70,000. These networks will receive an additional allocation equal to the amount that these costs exceeded $70,000. This addresses not only the highest cost Complex Care patients, but also those in the Basic Care group.

VERA Changes Not Approved: There was one VERA change recommended for FY 2003 implementation that was not approved by the Secretary. GAO, in its February 2002 report (GAO-02-338) on VERA, recommended that VA "Better align VERA measures of workload with actual workload served regardless of veteran priority group."

Based on a careful assessment of all policy options, the Secretary decided to continue the past practice of excluding non-service-connected Priority 7 Basic Care patients from the VERA allocation model for FY 2003. Although the inclusion of non-service-connected Priority 7 veterans in the VERA Basic Care

category would be a step toward better aligning the VERA allocation model with VA's actual enrollment experience, including these veterans in the VERA model would create financial incentives to seek out more of these veterans instead of veterans with service connected disabilities or those with incomes below the current income threshold or special needs patients (e.g., the homeless), veterans who comprise VA's core health care mission.

VA experienced uncontrolled growth in the Priority 7 veterans when they were not included in the VERA model, and VA does not want to encourage unmanageable growth by including them in the VERA model. The allocation of fixed resources to networks is done on a zero sum basis. Increased resources for non-service-connected Priority 7 veterans would come at the expense of veterans who are service-connected, poor, or who require specialized services. Also, the allocation of resources to areas with a disproportionate percentage of non-service-connected Priority 7 veterans would come at the expense of veterans who live in areas with disproportionately higher numbers of service-connected and lower income veterans.

Workload

For each price group, a workload (i.e., the number of veterans upon which allocations will be made) must be established.

Basic Care: In anticipating the need to move toward a stable, capitation-based allocation methodology, VA chose to allocate the Basic Care resources using a workload measure representative of a population of potentially "enrolled" eligible veterans (i.e., a "proxy" enrollment). This population would be larger than just the forecasted count of veterans that would be cared for in a single year, because not all VA patients use health care services every year. Further, one-year forecasts can vary from year to year depending on annual changes in capacity and economic factors. This annual variation was thought to be counter to the concept of a stable subscriber base. Furthermore, the ideal database of current eligible veterans (users and nonusers) by network for the years covered by the VERA workload volume is not robust enough for resource allocation purposes.

After considerable analysis, VA chose to use the count of eligible veterans who had used VA services during three prior years, i.e., in any of the years FY 1999, FY 2000 and FY 2001. "Eligible veterans" was further defined to include only Priority 1 – 7 veterans, excluding those Priority 7 veterans whose illness is non-service-connected. This group included veterans with service-connected disabilities; veterans with income below the established dollar threshold; veterans who receive compensation and pension exams; World War I veterans; ex-Prisoners of War; veterans with special statutory eligibilities based on exposures

to Agent Orange in Vietnam, radiation from a nuclear detonation, or an environmental hazard or toxic substance in the Persian Gulf; and domiciliary patients. The use of Priority 1 – 7 veterans (excluding veterans whose illness is non-service-connected) as the basis of the allocation provides an equity of access dimension to VA health care resource management because it links funding to veterans who have the highest priority for care under authorizing legislation.

In FY 2003, VERA has expanded from three to ten price groups. There are six (1 through 6) Basic Care price groups and four (7 through 10) Complex Care price groups. A separate price for each of the six Basic Care price groups has been established based on the relative cost of each group. For FY 2003, these price groups are 1) Non Reliant Care, 2) Basic Medical, 3) Mental Health, 4) Heart, Lung, and Gastrointestinal, 5) Oncology, and 6) Multiple Problem. All veteran users seen over a 3-year period, FY 1999 through FY 2001, excluding non-service-connected Priority 7 veterans in the VERA Basic Care category, are incorporated into the network's FY 2003 VERA allocation.

Complex Care: The nature and

Table 1: Composition of VERA 10 Price Groups

VERA 10 Group Name & No.	VERA Class No.	VERA Class Name
1. Non Reliant Care: Basic Non-Vested / Vested		
	1	Employee/Collateral *
	2	Pharmacy *
	3	Compensation and Pension Exams
	4	Non-Vested
2. Basic Medical: Basic Vested		
	5	Ear, Nose and Throat
	6	Other Acute Diseases
	7	Endocrine, Nutritional, Metabolic Disorders
	8	Central Nervous System
	9	Musculoskeletal Disorders
3. Mental Health: Basic Vested		
	10	Acute Mental Disease
	11	Addictive Disorders
4. Heart, Lung & GI: Basic Vested		
	12	Cardiovascular Disease
	13	Gastroenterology Disorder
	14	Pulmonary Disease
5. Oncology: Basic Vested		
	15	Hepatitis C without Anti-viral Therapy
	16	HIV without Anti-retroviral Therapy
	17	Oncology
6. Multiple Problem: Basic Vested		
	18	Medical/Psychiatry +Substance Abuse
	19	Psychiatry + Substance Abuse
	20	Multiple Medical
	21	Post Tramautic Stress Disorder (PTSD) Acute
7. Specialized Care: Complex		
	22	Hepatitis C with Anti-viral Therapy
	23	HIV with Anti-retroviral Therapy
	24	Chronic PTSD
	25	Home Based Primary Care (HBPC)
	26	Traumatic Brain Injury (TBI)
8. Supportive Care: Complex		
	27	Stroke
	28	Domiciliary
	29	Spinal Cord Injury (SCI) Para-old Injury
	30	SCI Quad-old Injury
	31	Blind Rehabilitation Service
	32	Community Nursing Home
	33	Long Term Care: Low Activities of Daily Living (ADL)
9. Chronic Mental Illness: Complex		
	34	Mental Health Intensive Case Management
	35	Other Psychosis
	36	Substance Abuse
	37	Schizophrenia & Dementia
10. Critically Ill: Complex		
	38	End Stage Renal Disease (ESRD)
	39	SCI Para-new Injury
	40	SCI Quad-new Injury
	41	Long Term Care: Clinical Complex
	42	Long Term Care: Behavioral
	43	Long Term Care: Physical
	44	Long Term Care: Rehabilitation
	45	Long Term Care: Specialized Care
	46	Transplants
	47	Ventilator Dependent

* Care delivered to a veteran classified as "employee/collateral" and/or "pharmacy" is only included under the VERA methodology in conjunction with care delivered to that veteran in other classes.

Note: Detailed information on the patient classifications can be found in the VERA Handbook. The chapter is located on the Allocation Resource Center Website (http://vaww.arc.med.va.gov).

treatment needs of the Complex Care user population is considerably different than that of the Basic Care users. Complex Care patients are high-intensity users. Their average price is nearly 10 times greater than that of the average Basic Care patient, are cared for by the VA throughout each year (with multiple visits over 12 months), and receive care over the course of many years (i.e., they use VA year after year). Almost all of these patients will use VA's special emphasis programs services at some time during each year. The annual turnover rate (the percent of veterans seen each year who are not seen the following year) for Complex Care patients is usually less than 5% (as compared to 20% for Basic Care).

As in the past, the Complex Care workload is forecasted based on the number of Complex Care patients who used VA services during the past five years. The FY 2003 Complex Care workload is a forecasted trend of workload based on veterans who used the VA health care system from FY 1997-FY 2001. For FY 2003, the Complex Care price groups represent the four highest groups in the VERA-10 model. They are: 7) Specialized Care, 8) Supportive Care, 9) Chronic Mental Illness, and 10) Critically Ill.

While determining the workload for each of the two patient groups, VA had to ensure that VERA recognizes and accounts for veterans who receive their health care in more than one network. A typical example is the veteran who lives in New York, but spends a significant part of the year in Florida. To account for these veterans, VERA provides each network with a proportion of the price for each veteran who has historically received care in different locations. For example the New York City Network may get 60% of the workload for a Basic Care veteran, and the Florida Network may get 40% if the veteran received 60% of his care at New York facilities and 40% at Florida facilities. The proportions are based on the actual base year costs of the care for these veterans in each network.

Table 2 shows the expected network-specific workload (in numbers of veterans) for the Basic Care and Complex Care elements for the

Table 2: Basic and Complex Care Workload FY 2003

Network	Basic Care	Complex Care
1 Boston	168,178	6,930
2 Albany	102,723	5,054
3 Bronx	155,915	8,164
4 Pittsburgh	211,533	7,795
5 Baltimore	99,953	5,579
6 Durham	184,527	7,773
7 Atlanta	224,880	9,392
8 Bay Pines	337,811	13,176
9 Nashville	186,779	6,386
10 Cincinnati	133,592	7,088
11 Ann Arbor	156,100	5,895
12 Chicago	148,186	8,390
15 Kansas City	153,763	5,704
16 Jackson	343,040	11,180
17 Dallas	182,163	7,462
18 Phoenix	169,178	5,541
19 Denver	105,801	3,821
20 Portland	167,429	7,340
21 San Francisco	169,105	7,137
22 Long Beach	211,466	8,608
23 Minneapolis	167,766	7,325
VHA totals	3,779,887	155,739

Note: The numbers may not add due to rounding.

FY 2003 VERA allocation. The six price group Basic Care and four price group Complex Care allocation method ensures that the differences in case-mix are appropriately resourced. VERA provides each VISN an allocation that recognizes its individual characteristics and its appropriate share of the ten price groups. Workload for the ten price groups as well as specific formulas and back-up data used to create this table are included in Appendix 1.

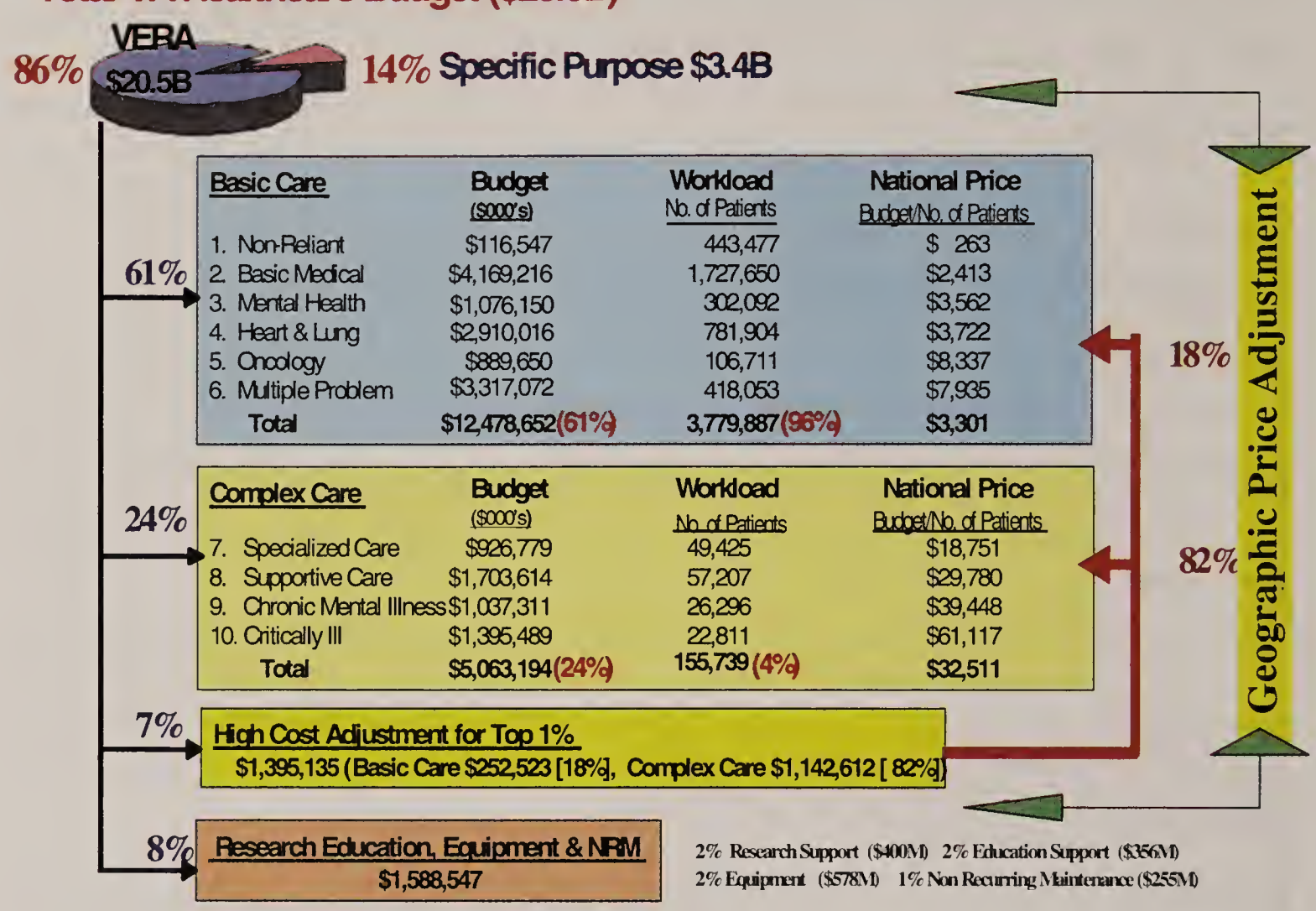
Setting the Price

The VERA methodology establishes a national price for each of the ten price groups by dividing the total dollars available in each of the groups by the workload in each group. The total dollars available in the ten price groups is determined by taking the FY 2003 Medical Care budget and allocating to each of the ten groups based on the ratio of each group's actual FY 2001 DSS (Decision Support System) costs to total cost of all groups. The total dollars available for the Basic and Complex Care groups in FY 2003 is $17.54 billion after removing the allocation for the top 1% high-cost patients. Of this amount, 28.9% is available for Complex Care ($5.06 billion) and 71.1% is available for Basic Care ($12.48 billion). The percent of the Basic Care provided to the six Basic Care price groups is based on the proportion of FY 2001 Basic Care actual FY 2001 DSS costs experienced in these price groups. The amount provided to the four Complex Care price groups is based on the proportion of FY 2001 Complex Care actual FY 2001 DSS costs experienced in these price groups.

Figure 2 shows the FY 2003 VA health care budget; total funding for the six Basic Care and four Complex Care price groups; the VERA workload; and the resultant national prices for each unit of workload in the ten groups.

These national prices for the ten groups are multiplied by the level of workload for each group in a network to calculate the ten price group allocations.

Figure 2: Establishing VERA National Prices, FY 2003



Network allocations for the six Basic Care price groups and the four Complex Care price groups are combined into the Basic Care and Complex Care allocations and are presented in Table 3. Formulas and back-up data used to create these allocations are included in Appendix 1.

Table 3: Network Basic Care and Complex Care Allocations FY 2003
($ in millions)

Network	Basic Care Workload	Basic Care Allocation	Complex Care Workload	Complex Care Allocation
1 Boston	168,178	$583	6,930	$235
2 Albany	102,723	$334	5,054	$156
3 Bronx	155,915	$532	8,164	$255
4 Pittsburgh	211,533	$666	7,795	$277
5 Baltimore	99,953	$325	5,579	$178
6 Durham	184,527	$613	7,773	$262
7 Atlanta	224,880	$726	9,392	$290
8 Bay Pines	337,811	$1,163	13,176	$405
9 Nashville	186,779	$623	6,386	$211
10 Cincinnati	133,592	$437	7,088	$232
11 Ann Arbor	156,100	$523	5,895	$195
12 Chicago	148,186	$502	8,390	$286
15 Kansas City	153,763	$515	5,704	$180
16 Jackson	343,040	$1,138	11,180	$360
17 Dallas	182,163	$577	7,462	$259
18 Phoenix	169,178	$560	5,541	$173
19 Denver	105,801	$344	3,821	$119
20 Portland	167,429	$535	7,340	$234
21 San Francisco	169,105	$552	7,137	$231
22 Long Beach	211,466	$692	8,608	$279
23 Minneapolis	167,766	$539	7,325	$248
VHA totals	3,779,887	$12,479	155,739	$5,063

Basic Care workload and allocations are the sum of Basic Care price groups 1-6. Complex Care workload and allocations are the sum of Complex Care price groups 7-10. This chart does not include the allocations for High Cost Patients.

Note: The numbers may not add due to rounding.

VERA Ten Price Case-mix

VERA ten price case-mix is established in VERA with the ten price groups. Case-mix can be measured by the ratio between the network's current Basic Care and Complex Care allocations and a single price. This measurement depicts the case-mix that is already built into the VERA allocations due to network differences in workload and separate prices for the six Basic Care and four Complex Care groups of patients. The case-mix at the VHA national level is 1.0 and each network's case-mix is shown in Table 4. The table displays that there are variances in case-

mix among networks. For example, Network 3, Bronx, has a VERA case-mix of 1.19 which is 19% above the national average, and Network 18, Phoenix, has a VERA case-mix of .91, which is 9% below the national average. Network total workload can be multiplied by its case-mix index and a single national price to calculate the network's total allocations for the Basic Care and Complex Care workload components of VERA. VHA is currently studying other case-mix measures, such as Diagnostic Cost Groups, that may improve the risk-adjustment of the VERA methodology. Formulas and back-up data used to create the VERA ten price case-mix are included in Appendix 1.

Table 4: VERA Ten Price Group Case-Mix

Network	Case-Mix
1 Boston	1.07
2 Albany	1.02
3 Bronx	1.19
4 Pittsburgh	0.96
5 Baltimore	1.09
6 Durham	1.02
7 Atlanta	0.97
8 Bay Pines	0.98
9 Nashville	0.94
10 Cincinnati	1.06
11 Ann Arbor	1.01
12 Chicago	1.16
15 Kansas City	0.95
16 Jackson	0.93
17 Dallas	0.98
18 Phoenix	0.91
19 Denver	0.93
20 Portland	0.98
21 San Francisco	1.03
22 Long Beach	1.01
23 Minneapolis	0.99
VHA totals	1.00

Adjustment of the National Prices

It is recognized that some factors affecting the cost of a patient's care vary by geographic region of the country and cannot be controlled by VA management. VA considered a number of adjustments to the national price that were outside the network's ability to manage. These included such things as: age of patients, cost of labor, fuel and utilities costs, grounds management, fire departments, contract services, pharmaceuticals and beneficiary travel. However, after careful analysis and review, it was determined that only one adjustment was appropriate. This was called the geographic price adjustment.

Geographic Price Adjustment

VA determined the most significant factor that is uncontrollable at the network level is the cost of labor. VA labor costs account for about 65% of the total Basic and Complex Care funding. Salary costs continue to vary across the country due to geographic differences in labor costs. Generally, the costs tend to be higher in the northeast, the West Coast and large urban areas, and lower in rural, southern and mid-western areas. To account for the variations in the cost of labor in different parts of the country, network allocations are adjusted according to the cost of wages. This geographic price (labor) adjustment has been based on actual labor costs paid by VA facilities as they compare to a national average salary. The

purpose of the adjustment is to "level the playing field" and equalize the effect of salary differences among networks.

VA considered several approaches to calculating the labor index, including that used by the Centers for Medicare and Medicaid Services (CMS). However, the CMS data had several limitations when applied to VA. These limitations included the lack of inclusion of physician salaries and the cost of outpatient care. As a result, for the FY 1997, FY 1998 and FY 1999 network allocations, VA decided to use a VA-specific index, computing differences in average salary determined at the payroll personal services sub-account level. The sub-accounts were used to make the index as specific as possible for different classes of VA employees. For example, average salaries for registered nurses (RNs) at the network were compared to the RN national average salary; network clerical salaries were compared to the national VA average clerical salary, etc. The labor index included 93% of total systemwide salary dollars in its calculation.

For the FY 1999 network allocations, the geographic price (labor) adjustment was changed to use the most recent and accurate data available to properly reflect the considerable efforts of networks to manage their manpower expenditures. To that end, the labor index in the FY 1999 VERA model was based on the most recent four pay-periods during FY 1998. This was used in place of the cumulative actual year-end FY 1997 personal services data because it more accurately reflected current staffing levels and costs among the networks. Also in FY 1999, the geographic price index did not include the effect of holiday, standby, and overtime pay that reflects more truly the networks' controllable payroll. For the FY 2000 network allocations the geographic salary adjustment was changed to adopt the labor index methodology recommended by PricewaterhouseCoopers LLP in the *Veterans Equitable Resource Allocation Assessment Final Report.* This methodology differs from the previous methodology in that it uses a national market basket approach in the formula to create the index, instead of network level staffing patterns. By using national data, the index formula does not intermingle staffing differences with salary variables. Therefore, the index is generated based upon the specific differences in labor cost.

For FY 2001, the workload factor for computing the labor index was changed to weight Complex Care workload consistent with recent costs. This change accounts for the more intense and expensive staffing level required for Complex Care patients. It weights Complex Care patients approximately 10 times more heavily than Basic Vested Care patients in the application of the geographic price adjustment.

Prior to FY 2002, only salary costs were included in computing the geographic price adjustment. However, the FY 2002 VERA methodology was modified to include additional network expenses that are affected by local cost of living factors. For example, network-level procurements for contracted labor and certain non-labor contracted goods (such as energy-related products, utilities and provisions) can vary due to local cost of living factors. To ensure that network allocations reflect these regional cost variances, expenditures for these goods and services are now subject to a geographic adjustment. This modification accounts for expenses caused by geographic cost factors that are beyond a network's immediate control.

Table 5 shows how much the network allocations under the Basic and Complex Care groups are adjusted by the geographic price (labor index) adjustment. Specific formulas and back-up data used to create this table are included in Appendix 1.

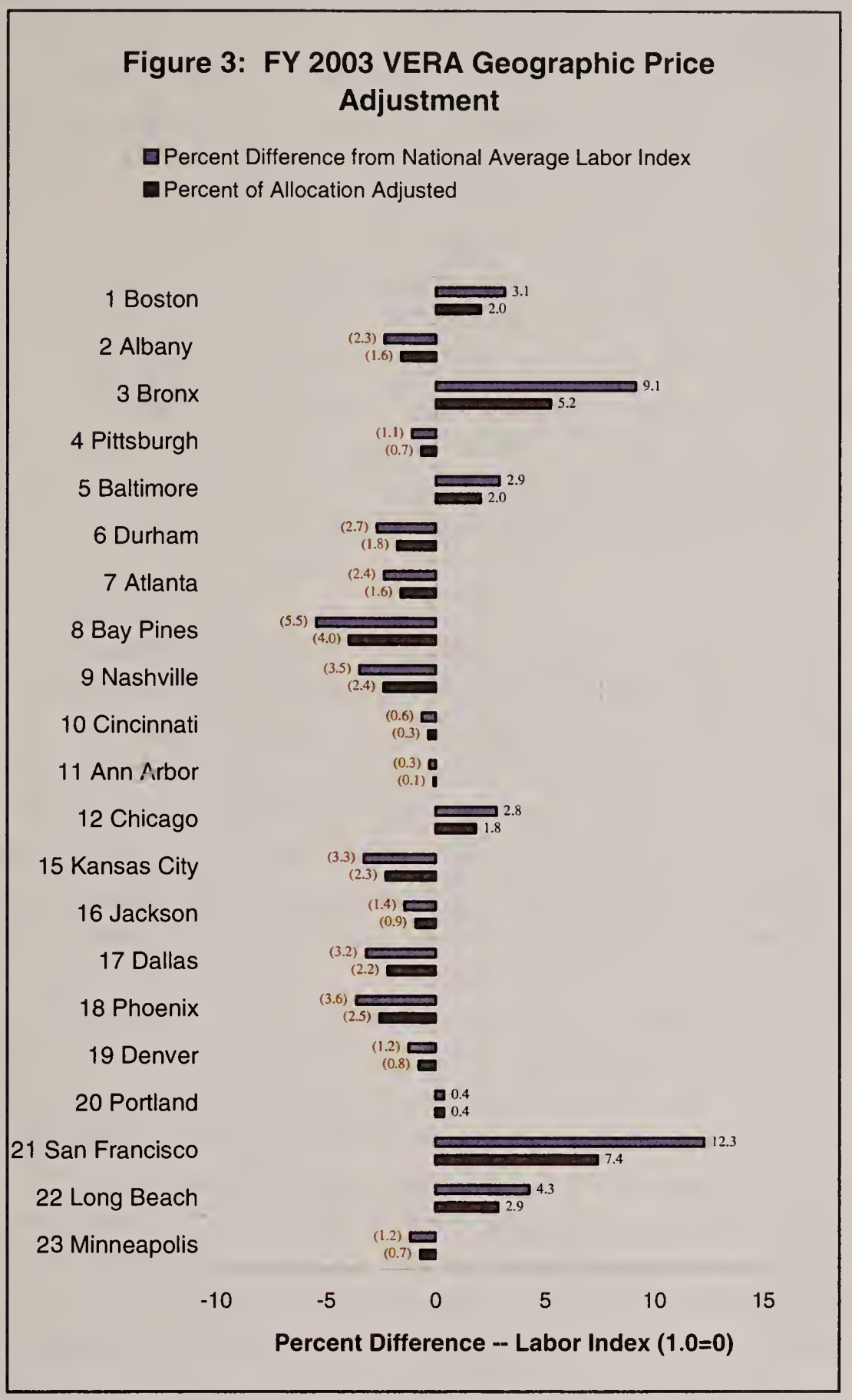
Figure 3 on page 15 shows for FY 2003 the actual VHA labor index by network in terms of the percentage impact on the annual network allocation.

Table 5: Geographic Price Adjustment
($ in millions)

Network	Labor Index	Adjustment to Allocations
1 Boston	1.031	$21
2 Albany	0.977	-$9
3 Bronx	1.091	$58
4 Pittsburgh	0.989	-$7
5 Baltimore	1.029	$13
6 Durham	0.973	-$18
7 Atlanta	0.976	-$19
8 Bay Pines	0.945	-$66
9 Nashville	0.965	-$22
10 Cincinnati	0.994	-$3
11 Ann Arbor	0.997	-$1
12 Chicago	1.028	$18
15 Kansas City	0.967	-$17
16 Jackson	0.986	-$15
17 Dallas	0.968	-$20
18 Phoenix	0.964	-$20
19 Denver	0.988	-$4
20 Portland	1.004	$3
21 San Francisco	1.123	$79
22 Long Beach	1.043	$35
23 Minneapolis	0.988	-$6
VHA totals	1.000	$0

Note: The numbers may not add due to rounding.

Figure 3: FY 2003 VERA Geographic Price Adjustment



Research Support

VA's Medical Care appropriation funds a variety of activities that support its research mission. Research support is not included in the Basic and Complex Care allocation because the costs of research support are not directly related to patient workload. VA, however, designed all elements in the VERA system to allocate resources on the basis of workload. The total dollars of funded research was

selected as the appropriate workload indicator for allocating research support funds. For FY 2003, $400 million will be allocated for research support. This amount is based on the estimates for Medical Care support to research as submitted in the President's FY 2003 Medical Programs Budget Request. Prior to FY 2000, this element simply allocated the national funding level for research support to the networks. The actual level of support expenditures was determined by network management in the context of network-wide operations. In FY 2000, networks passed through the research support allocation as it is computed for each Medical Center "Care Line" or "Product Line." Each Medical Center, Care Line, or Product Line explicitly accounted for, and obligated, research support funds to support the salaries of clinician-researchers, and research facilities and administrative costs. Also during FY 2000, VA established a VERA Research Accounting Team to develop a methodology to more accurately account for the salaries of clinician-researchers and other medical care funds spent in support of research.

For FY 2001 and FY 2002, VA continued the pass-through of VERA research support allocations directly to each Medical Center, Care Line, or Product Line to support the salaries of clinician-researchers, and research facilities and administrative costs. During FY 2001, VA conducted a Beta Test of the new research support accounting methodology at selected facilities. As a result of this Beta Test, the new research support accounting methodology was instituted at all VA facilities and applied retroactively to FY 2000 and FY 2001 data. VA also took action to begin integrating this new accounting methodology into DSS during FY 2002.

Since FY 1999, the workload allocation factor for the distribution of the VERA research support dollars has been to weight VA-administered research at 100%; non-VA funded, non-VA administered, peer reviewed research at 75%; and other non-VA funded, non-VA administered, non-peer reviewed research at 25%. VA-administered research expenditures can be reliably audited for accuracy because either the VA's own acquisition and fiscal offices or the non-profit Medical Center Research corporations are used. Non-VA administered research expenditures are self-reported and rely on that data for accuracy. By weighting VA-administered research at 100% and discounting non-VA administered research, there is an incentive to encourage VA administered research. Table 6 displays the FY 2003 network allocations for the research support component. Specific formulas and back-up data used to create the research support allocations are included in Appendix 1.

Research support from the Medical Care budget includes personal services costs for individuals on the Medical Care rolls who spend a portion of their VA time working on research projects. Additionally, administrative support provided to the

Research Program by Fiscal, Engineering, Acquisition and Materiel Management, etc., are reported as research support. Research support also includes support for all aspects of the program, including projects funded from VA's Research appropriation, through extramural grants, through the General Post Fund or, in some cases, through non-profit Medical Center Research Corporations. The total research funding that is used as the basis for prorating the research support funds does not include animal research or administrative costs. Table 6 shows that the total funded Research reported in FY 2001 was $882 million. After applying the weights for the FY 2001 VA and non-VA research expenditures, the weighted amount of reported funded research is adjusted to $740 million.

Table 6: Research Support Allocation
($ in millions)

Network	FY 2001 Funded Research Reported	FY 2001 Funded Research Reported and Weighted*	FY 2003 Research Support Allocation
1 Boston	$69	$61	$33
2 Albany	$9	$8	$4
3 Bronx	$26	$21	$12
4 Pittsburgh	$34	$28	$15
5 Baltimore	$43	$35	$19
6 Durham	$26	$24	$13
7 Atlanta	$39	$34	$19
8 Bay Pines	$33	$24	$13
9 Nashville	$31	$26	$14
10 Cincinnati	$30	$25	$13
11 Ann Arbor	$40	$32	$17
12 Chicago	$48	$40	$21
15 Kansas City	$10	$8	$5
16 Jackson	$47	$37	$20
17 Dallas	$37	$29	$16
18 Phoenix	$18	$17	$9
19 Denver	$16	$14	$8
20 Portland	$50	$42	$23
21 San Francisco	$109	$94	$51
22 Long Beach	$108	$93	$50
23 Minneapolis	$58	$47	$25
VHA totals	$882	$740	$400

Note: The numbers may not add due to rounding.

* Weights are based on the type of research activity: 100% for research which is administered by the VA; 75% for research which is peer reviewed but not VA administered; 25% for research which is not peer reviewed.

Education Support

Similar to research, VA's Medical Care appropriation funds a variety of activities supporting its education mission. Education support is not included in the Basic and Complex Care rates because the costs of education support are not consistent across all networks. Because VA designed all components of VERA to allocate resources on the basis of workload, the total number of residents was selected as the appropriate workload indicator for allocating education support funds to each network. A VERA education workgroup reviewed the education support allocation component methodology and concluded that the allocation should continue to be based on a national price per medical resident and the total number of residents in a network. The workgroup reached this conclusion because there is a strong statistical correlation between the number of medical residents and the reported educational support expenditures. Moreover, its analysis showed that there is also a strong statistical correlation between the number of medical resident

positions and the number of individual associated health trainees. These findings strongly support the case of medical resident positions as the basis for the allocation of education support funds to the networks.

As shown in Table 7, $356 million is allocated for education support in FY 2003. This figure is based on the reported amounts of expenditures for Medical Care support to education as estimated in the President's FY 2003 Medical Programs Budget Request.

Table 7: Education Support Allocation
($ in millions)

Network	Number of Residents	Allocation
1 Boston	514	$21
2 Albany	240	$10
3 Bronx	602	$24
4 Pittsburgh	322	$13
5 Baltimore	248	$10
6 Durham	369	$15
7 Atlanta	442	$18
8 Bay Pines	564	$23
9 Nashville	545	$22
10 Cincinnati	260	$11
11 Ann Arbor	317	$13
12 Chicago	652	$26
15 Kansas City	331	$13
16 Jackson	680	$28
17 Dallas	338	$14
18 Phoenix	312	$13
19 Denver	235	$9
20 Portland	278	$11
21 San Francisco	405	$16
22 Long Beach	736	$30
23 Minneapolis	399	$16
VHA totals	8,787	$356

Note: The numbers may not add due to rounding.

Education support dollars are computed by determining each network's portion of VA residents, compared to the national resident allocation for academic year 2002-2003. This equates to an education support allocation of $40,469 for each resident. It is important to note that this element simply allocates the national funding level for education support to the networks, and that the actual level of support expenditures will be determined by network management in the context of network-wide operations. Specific formulas and back-up data used to create the education support allocations are included in Appendix 1.

Equipment

Equipment is also included as a separate element. For the first few years of VERA implementation, VA recognized that equipment funding ultimately might be moved into the Basic and Complex Care elements of the VERA system. However, as a transitional step in the FY 1997 and FY 1998 network allocations, VA distributed equipment funding to networks based on the following formula: 50% on the basis of clinical complexity, 25% on patient workload, and 25% on the distribution of existing equipment. Beginning with the FY 1999 network allocations, the equipment component of VERA was changed to recognize the need to fund patients, not facilities, and to gradually phase equipment into the VERA Basic and Complex Care elements. The equipment element of the model was revised to use the Basic and Complex Care workload for each network as the

distribution factor. This element change was phased in over a two-year period to lessen the impact for those networks that would lose funds under this methodology. In FY 1999, 50% of the difference between the previous equipment methodology and the revised method was used to allocate equipment funds to networks. Beginning in FY 2000, the equipment allocation is based totally on patient workload. The total amount of equipment funding to be distributed to networks in FY 2003 is $578 million. Table 8 shows the equipment allocation to each network. Specific formulas and back-up data used to create the equipment allocations are included in Appendix 1.

Table 8: Equipment Allocation
($ in millions)

Network	Allocation
1 Boston	$26
2 Albany	$16
3 Bronx	$24
4 Pittsburgh	$32
5 Baltimore	$15
6 Durham	$28
7 Atlanta	$34
8 Bay Pines	$52
9 Nashville	$28
10 Cincinnati	$21
11 Ann Arbor	$24
12 Chicago	$23
15 Kansas City	$23
16 Jackson	$52
17 Dallas	$28
18 Phoenix	$26
19 Denver	$16
20 Portland	$26
21 San Francisco	$26
22 Long Beach	$32
23 Minneapolis	$26
VHA Total	$578

Note: The numbers may not add due to rounding.

Non-Recurring Maintenance (NRM)

In FY 1997 and FY 1998, network allocations of non-recurring maintenance required a separate adjustment to permit a smooth transition for funds to become fully patient-modeled and to allow flexibility in administering these funds. As with equipment, NRM was a separate element for several reasons. There is disparity among facilities in terms of NRM needs based on the cost of construction in each network, the square footage of buildings, and the number and age of buildings.

The workload indicators that were chosen as the basis for allocating NRM funds in FY 1997 and FY 1998 were the cost of construction adjusted for square footage and age of buildings in the network, and patient care workload. It was anticipated that initially a network's adjusted cost of construction would be used to allocate more of the funds, while later the majority of funds would be allocated based on patient care workload. For FY 1997 and FY 1998, 90% of the NRM dollars were allocated based on an index-adjusted cost of construction and 10% based on patient care workload. In the FY 1999 network allocations, the NRM component of VERA was changed to fund patients, not facilities, and was adjusted for differences in regional construction costs. This element change was phased in over a three-year period in equal increments to lessen the impact for those networks that will lose funds under this methodology. This was accomplished by: (1) using 100% of the patient care workload for each network and adjusting for the cost of construction using the Boeckh Index; and (2) adding 33% of the difference

between the previous NRM methodology and the revised method in FY 1999, 66% in FY 2000 and 100% in FY 2001. FY 2001 completed the three-year phase-in of NRM being fully based on patient care workload and the cost of construction using the Boeckh Index. For FY 2003, VA will allocate $255 million in NRM funds. Table 9 depicts the NRM allocation for each network. Appendix 1 includes specific formulas and back-up data used to create the non-recurring maintenance allocations.

Table 9: Non-Recurring Maintenance Allocation
($ in millions)

Network	Allocation
1 Boston	$13
2 Albany	$8
3 Bronx	$16
4 Pittsburgh	$16
5 Baltimore	$7
6 Durham	$9
7 Atlanta	$12
8 Bay Pines	$19
9 Nashville	$11
10 Cincinnati	$10
11 Ann Arbor	$12
12 Chicago	$12
15 Kansas City	$11
16 Jackson	$18
17 Dallas	$10
18 Phoenix	$10
19 Denver	$6
20 Portland	$13
21 San Francisco	$15
22 Long Beach	$17
23 Minneapolis	$11
VHA Total	$255

Note: The numbers may not add due to rounding.

Adjustment for Top 1% High Cost Patients

In FY 2003, VHA established a 1% high cost threshold that recognizes the impact on networks with patients whose annual costs exceed a threshold of $70,000. Networks will receive an additional allocation for patients whose cost exceeds the $70,000 threshold. For example, transplant patients are now included in the VERA-10 Critically Ill price group, i.e., the highest price group at $61,117. Any network with transplant patient costs above the newly established 1% high cost threshold will receive an additional allocation equal to the amount of actual cost above $70,000. Therefore, a network will receive the VERA-10 Critically Ill price group allocation of $61,117 plus the full cost that exceeds the $70,000 threshold. In the case of a $125,000 transplant patient, a network will receive an allocation of $61,117, plus $55,000. Appendix 1 includes the data on network Basic and Complex Care patients receiving high cost payments and corresponding allocations in each of the 10 Price Groups.

Minimum and Maximum Caps on FY 2003 Allocation Increases

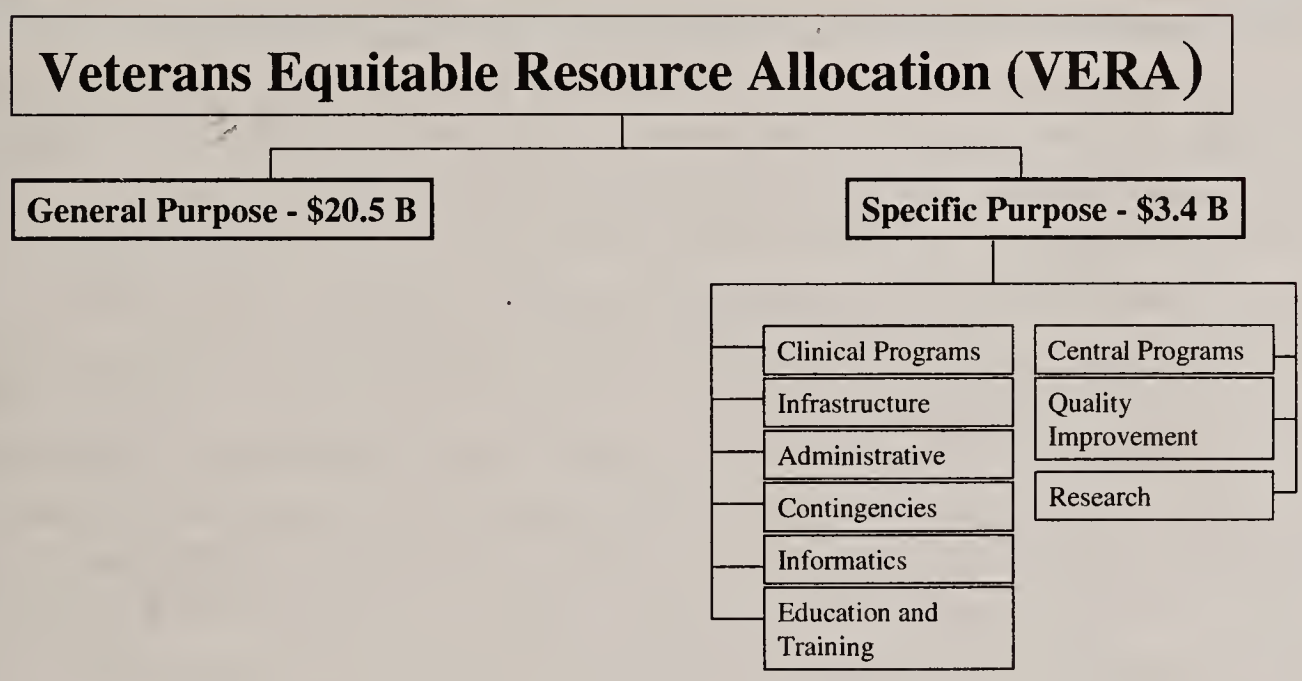
This element provides that networks will receive a minimum five percent allocation increase above the final amount received in FY 2002 (includes: initial FY 2002 allocation, an additional $162 million from Specific Purpose Funds, $6.8 million World Trade Center Funding adjustment to Network 3, $142 million supplemental appropriation funding, and $82.4 million from the National Reserve Fund, which includes $17.4 million for Network 1's operational shortfall). In

order to pay for the increases so that any network that would be receiving less than a five percent increase above the final amount received in FY 2002 would be increased to five percent, VA has instituted a ceiling on fast-growing networks. Funding increases for all the networks will be capped at 12.6 percent over the final amount received in FY 2002. This high cap is expected to discourage unmanaged workload growth. Appendix 1 and Section II, VERA Results, display the data and impact on networks due to the minimum and maximum caps on the FY 2003 allocation increases.

Specific Purpose Funds

Figure 4 reflects the Specific Purpose funding components.

Figure 4: Components of Specific Purpose VERA Funding



VERA also contributes to the goal of decentralizing day-to-day management of the system to the networks by transitioning from Specific Purpose to General Purpose funding. Under the previous RPM allocation model, a substantial portion of funding (21%) was controlled through VA Headquarters committees – i.e., those funds were not allocated through the model. To provide greater budget flexibility to networks, a higher proportion of funds have been shifted into the VERA model (funds distributed at the beginning of the fiscal year to the field based on projected workload). This shift from Specific Purpose to General Purpose was based on an examination of all Specific Purpose activities. That

examination concluded that activities should be funded from Specific Purpose resources only if they meet at least one of the following three criteria:

1. Efficiency. There is a demonstrable savings with central management (e.g., leverage of buying power through national contracts).

2. Legal or programmatic requirements. There is a specific statutory requirement that limits VA's ability to decentralize the program or function.

3. National support. The item is judged to be essential for the corporate management of VA and is something that would be outside of the scope of network operations.

After applying these criteria, it was determined that Specific Purpose funding should be reduced by 42% (from $3.52 billion to $2.06 billion), with the $1.46 billion difference going into the VERA model funding for FY 1997. As a result, about 88% of the FY 1997 Medical Care budget was distributed through the VERA components and only 12% allocated to the field through Specific Purpose allocation. Some of the programs that were shifted to the model were: equipment, community nursing homes, non-recurring maintenance, tuition support, permanent change of station (moving expenses) and terminal leave. In FY 1998, VA continued to move funding from Specific Purpose to General Purpose. The FY 1998 allocations showed a slight increase in General Purpose funding and a slight decrease in Specific Purpose dollars – 89% ($15.2 billion) of the FY 1998 Medical Care budget was distributed through the VERA components, and only 11% ($1.9 billion) allocated to the field through Specific Purpose allocations. The amount distributed through VERA components in FY 1999 was 89% ($15.3 billion) and 11% ($2.0 billion) was managed as Specific Purpose funding. A field-based workgroup further reviewed the Specific Purpose activities in preparation for the FY 2000 allocation. As a result, the amount distributed through General Purpose funding in FY 2000 was 89% ($16.8 billion) and 11% ($2.1 billion) was managed as Specific Purpose funding. The Under Secretary for Health decided to centralize funding for prosthetics for FY 2001. As a result of this decision, $205 million moved from General Purpose funding to Specific Purpose funding. With this decision and other actions from the Specific Purpose workgroup, the amount distributed through General Purpose funding in FY 2001 was 88% ($17.75 billion) and 12% ($2.54 billion) was managed as Specific Purpose funding. The field-based workgroup again reviewed the Specific Purpose funding for FY 2002. The amount distributed through General Purpose funding in FY 2002 was 87% ($18.70 billion) and 13% ($2.74 billion) was managed as Specific Purpose funding in FY 2002. The field-based workgroup continued to review the Specific Purpose activities for the FY 2003 allocations. The amount

distributed through General Purpose funding in FY 2003 will be 86% ($20.53 billion) and 14% ($3.37 billion) will be managed as Specific Purpose funding. Over 60% of these Specific Purpose funds are for the following programs: prosthetics, state homes and homeless, clinical trainees, and CHAMPVA.

Section II
VERA Results

Table 10 summarizes the results of the FY 2003 VERA model for each network. Appendix 1 includes specific formulas and back-up data used to create these results.

Table 10: Results of VERA Model - FY 2003
($ in millions)

Network	Basic and Complex Care Workload with Geographic Price Adjustment*	High Cost Patient Funding	Research Support	Education Support	Equipment	NRM	5% Capping	Total
1 Boston	$838	$82	$33	$21	$26	$13	$0	$1,012
2 Albany	$481	$38	$4	$10	$16	$8	$0	$556
3 Bronx	$845	$152	$12	$24	$24	$16	$38	$1,112
4 Pittsburgh	$936	$71	$15	$13	$32	$16	-$6	$1,077
5 Baltimore	$516	$51	$19	$10	$15	$7	$0	$618
6 Durham	$858	$67	$13	$15	$28	$9	$0	$991
7 Atlanta	$997	$79	$19	$18	$34	$12	$0	$1,159
8 Bay Pines	$1,502	$80	$13	$23	$52	$19	-$33	$1,656
9 Nashville	$812	$40	$14	$22	$28	$11	$0	$927
10 Cincinnati	$666	$51	$13	$11	$21	$10	$0	$771
11 Ann Arbor	$718	$66	$17	$13	$24	$12	$0	$849
12 Chicago	$806	$89	$21	$26	$23	$12	$0	$978
15 Kansas City	$677	$32	$5	$13	$23	$11	$0	$761
16 Jackson	$1,483	$88	$20	$28	$52	$18	-$1	$1,689
17 Dallas	$816	$54	$16	$14	$28	$10	$0	$937
18 Phoenix	$713	$33	$9	$13	$26	$10	$0	$803
19 Denver	$459	$30	$8	$9	$16	$6	$0	$528
20 Portland	$772	$58	$23	$11	$26	$13	$0	$903
21 San Francisco	$862	$92	$51	$16	$26	$15	$0	$1,062
22 Long Beach	$1,006	$97	$50	$30	$32	$17	-$12	$1,220
23 Minneapolis	$781	$45	$25	$16	$26	$11	$13	$918
VHA Total	$17,542	$1,395	$400	$356	$578	$255	$0	$20,526

Note: The numbers may not add due to rounding.
*This includes $15.3 billion for special programs, see Appendix 1.

In addition to moving from VERA-3 to VERA-10 price groups for FY 2003, VHA implemented a top 1% High Cost Patient payment and low/high funding caps for all networks.

VA's implementation in FY 2003 of a low cap and a high cap on network allocation increases provides that all networks receive a minimum 5% increase and a maximum increase of 12.6% above the final amount received in FY 2002 (includes the initial FY 2002 VERA allocation with the VERA adjustments of $267.3 million to Networks 1, 3, 12, and 23, an additional $162 million from Specific Purpose Funds, $6.8 million World Trade Center Funding adjustment to Network 3, $142 million supplemental appropriation funding, and $82 million from the National Reserve Fund, which includes $17.4 million for Network 1's

operational shortfall). As a result, it is expected there will be no VERA adjustment or supplemental allocation provided in FY 2003. This is in contrast to the VERA supplemental funding adjustments that were provided to certain networks from FY 1999 to FY 2002, as described in Appendix 3. Table 10 shows the results of the 5% low cap and 12.6% high cap on networks' FY 2003 funding allocations.

Table 11 shows the impact of the VERA allocation on network budgets from FY 2002 to FY 2003. Specific formulas and back-up data used to create this table are included in Appendix 1.

Table 11: Changes in Network Budgets FY 2002 - FY 2003
($ in millions)

Network	FY 2002 General Purpose	FY 2003 General Purpose	Increase	% Increase
1 Boston	$943	$1,012	$69	7.31
2 Albany	$507	$556	$49	9.66
3 Bronx	$1,059	$1,112	$53	5.00
4 Pittsburgh	$956	$1,077	$121	12.63
5 Baltimore	$576	$618	$42	7.28
6 Durham	$882	$991	$109	12.37
7 Atlanta	$1,072	$1,159	$87	8.09
8 Bay Pines	$1,470	$1,656	$186	12.63
9 Nashville	$849	$927	$78	9.21
10 Cincinnati	$698	$771	$74	10.57
11 Ann Arbor	$766	$849	$83	10.82
12 Chicago	$899	$978	$79	8.84
15 Kansas City	$718	$761	$44	6.09
16 Jackson	$1,499	$1,689	$189	12.63
17 Dallas	$850	$937	$87	10.19
18 Phoenix	$732	$803	$71	9.77
19 Denver	$483	$528	$45	9.36
20 Portland	$840	$903	$63	7.46
21 San Francisco	$948	$1,062	$114	12.07
22 Long Beach	$1,083	$1,220	$137	12.63
23 Minneapolis	$874	$918	$44	5.00
VHA Total	$18,702	$20,526	$1,823	9.75

FY 2002 General Purpose includes VERA adjustment for four networks as well as additional funds distributed in February and August 2002.
Note: Numbers may not add due to rounding.

Table 12 shows the results of the VERA model without the 5% low cap and 12.6% high cap.

Table 12: FY 2003 VERA Outcome without 5% Low Cap

($ in millions)

Network	FY 2002	FY 2003 without 5% low cap	Percent Change
1 Boston	$943	$1,012	7.3%
2 Albany	$507	$556	9.7%
3 Bronx	$1,059	$1,073	1.4%
4 Pittsburgh	$956	$1,083	13.3%
5 Baltimore	$576	$618	7.3%
6 Durham	$882	$991	12.4%
7 Atlanta	$1,072	$1,159	8.1%
8 Bay Pines	$1,470	$1,688	14.8%
9 Nashville	$849	$927	9.2%
10 Cincinnati	$698	$771	10.6%
11 Ann Arbor	$766	$849	10.8%
12 Chicago	$899	$978	8.8%
15 Kansas City	$718	$761	6.1%
16 Jackson	$1,499	$1,689	12.7%
17 Dallas	$850	$937	10.2%
18 Phoenix	$732	$803	9.8%
19 Denver	$483	$528	9.4%
20 Portland	$840	$903	7.5%
21 San Francisco	$948	$1,062	12.1%
22 Long Beach	$1,083	$1,232	13.8%
23 Minneapolis	$874	$904	3.5%
VHA Total	$18,702	$20,526	9.7%

Note: Numbers may not add due to rounding.
FY 2002 General Purpose includes VERA adjustment for four networks as well as additional funds distributed in February and August 2002.

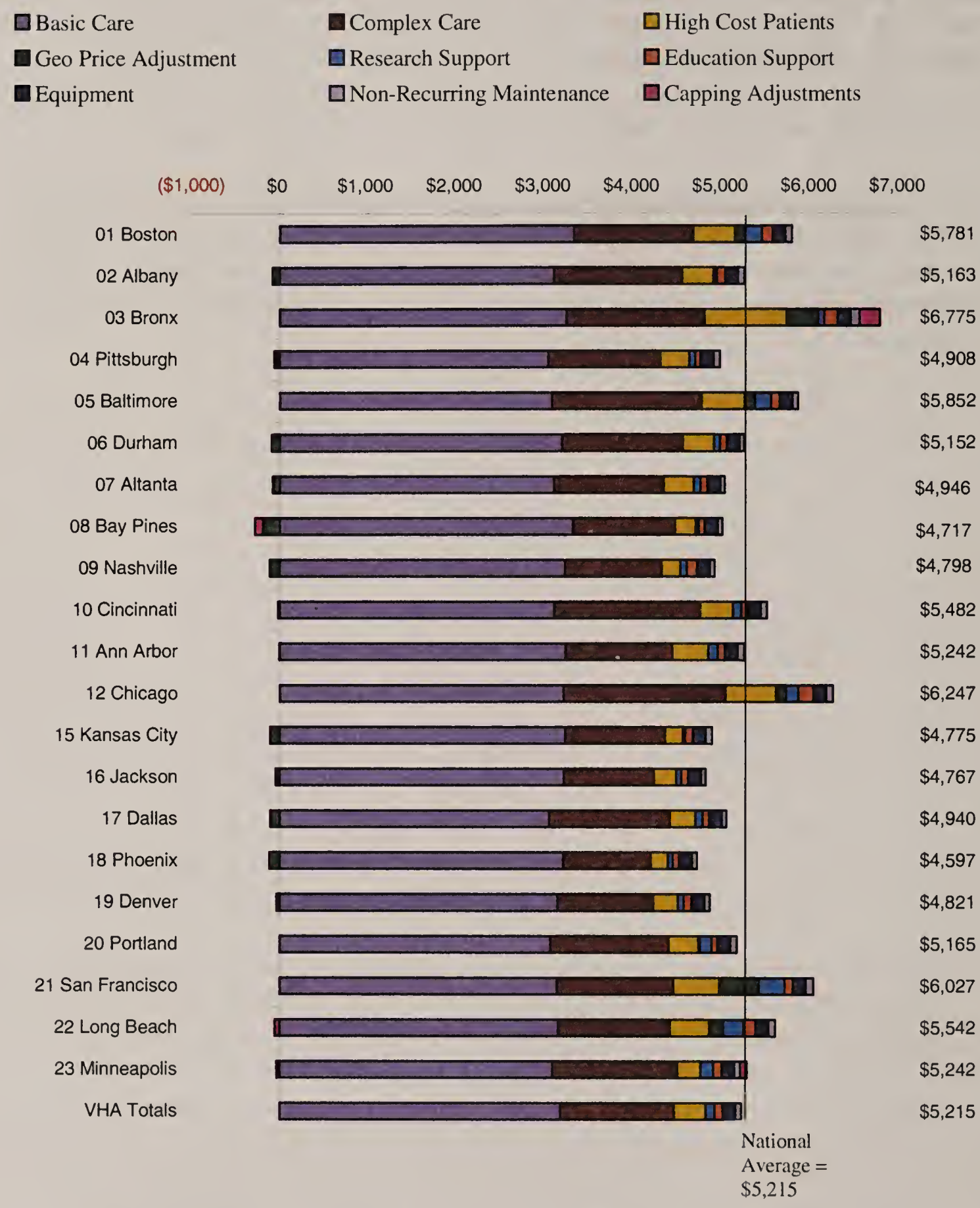
Figure 5 on page 28 shows the FY 2003 average price per patient for each network under the impact of the VERA model including the additional allocation for the top 1% high cost patients and the low and high capping adjustment. The network average price is calculated by dividing each network's total VERA funding by each network's total workload volume (i.e., Basic and Complex Care workload as shown in Table 2 on page 8). The graph displays the average dollars allocated to each network for Basic Care, Complex Care, top 1% high cost patients, geographic price adjustment, support to research and education, equipment, non-recurring maintenance, and the low and high capping adjustment.

Variances from the national average exist because VERA allocates funds in a manner that adjusts for differences in patient mix including high cost patients, geographic price adjustment, research and education support costs, and the

capping adjustment. Thus, even the networks with the lowest funding increases in FY 2003 compared to FY 2002 may still receive a higher than average price per patient than networks that receive more funding. For example, Network 3 receives the 5% low cap funding increase under VERA and has an average price of $6,775, which is 29.9% above the system average of $5,215. On the other hand, Network 8 receives the 12.6% maximum funding increase under VERA and has an average price of $4,717, which is 9.5% below the system average.

These variances demonstrate that VERA is not simply moving all networks to an average price per patient, but adjusts network allocations for differences in patient mix, high cost patients, geographic costs, research and education support costs, equipment and non-recurring maintenance activities, and the low and high capping adjustment.

Figure 5: Projected VERA Average Price by Network FY 2003



Note: Average price includes the long-term care, physicians' salaries, pharmaceuticals, treatment for mental illness, maintenance of historical buildings and other costs not included in all private or public health plan s (e.g., Medicare).

Legislative Mandate for VERA

On September 26, 1996, under Public Law 104-204, Section 429, Congress directed VA to implement a more equitable resource allocation system as described in the language below:

> ***SEC. 429 (a) PLAN.---(1) The Secretary of Veterans Affairs shall develop a plan for the allocation of healthcare resources (including personnel and funds) of the Department of Veterans Affairs among the healthcare Networks of the Department so as to ensure that veterans who have similar economic status and eligibility priority and who are eligible for medical care have similar access to such care regardless of the region of the United States in which such veterans reside. (2) The plan shall --(A) reflect, to the maximum extent possible, the Veterans Integrated Services Network developed by the Department to account for forecasts in expected workload and to ensure fairness to facilities that provide cost-efficient healthcare; and (B) include --(i) procedures to identify reasons for variations in operating costs among similar facilities where Network allocations are based on similar costs for similar services and workload; (ii) ways to improve the allocation of resources so as to promote efficient use of resources and provision of quality healthcare; (iii) adjustments to unit costs in subsection (a) to reflect factors which directly influence the cost of healthcare delivery within each Network and where such factors are not under the control of Network or Department management; and (iv) include forecasts in expected workload and consideration of the demand for Veterans Administration healthcare that may not be reflected in current workload projections. (3) The Secretary shall prepare the plan in consultation with the Under Secretary of Health of the Department of Veterans Affairs. (b) PLAN ELEMENTS - The plan under subsection (a) shall set forth --milestones for achieving the goal referred to in paragraph (1) of that subsection; and (2) a means of evaluating the success of the Secretary in meeting the goal. (c) SUBMITTAL TO CONGRESS -- The Secretary shall submit to Congress the plan developed under subsection (a) not later than 180 days after the date of enactment of this Act. (d)***
>
> ***IMPLEMENTATION -- The Secretary shall implement the plan developed under subsection (a) not later than 60 days after submitting the plan to Congress under subsection (c), unless within that time the Secretary notifies Congress that the plan will not be implemented in that time and includes with the notification an explanation why the plan will not be implemented in that time.***

Phase-In Implementation of VERA

To assure the magnitude of the impact on each network was manageable, VA phased-in the implementation of VERA through FY 1999 by limiting the annual losses of any individual network to 5%, exclusive of equipment and non-recurring maintenance funds.

The purpose of the phase-in period was to bridge to the new system. With the additional $1.62 billion increase (after a reduction in capital accounts) in FY 2000 over the FY 1999 budget level, the 5% cap limiting the loss of any network was no longer necessary because no network lost more than 5%. The phase-in period was completed in FY 2000. The phase-in period ensured that care was not disrupted and that veterans receiving care were not adversely affected by abrupt funding changes.

The Conference language that accompanied the Act (Public Law 104-204) (September 26, 1996) further explains congressional intent on the phase-in of VERA. The Conference Report (No.104-812) (September 20, 1996) states:

> ***The conferees recognize that precipitous changes in allocations amongst VA's facilities could be very difficult for individual facilities to manage. While the conferees support VA's efforts to amend its resource allocation methodology based on a capitation model—which is intended to bring about a more equitable distribution of resources—they expect the Department to ensure that fiscal year 1997 serve as a "bridge" in moving to the new system so as to provide an adjustment period for facilities to adapt to the new model. The conferees further expect that no veteran currently receiving care by the VA will be denied VA health care services as a result of the new allocation methodology. The VA is to prepare a report by January 31, 1997, on its progress in adjusting to and impacts of the new methodology, and be prepared to discuss this matter during the fiscal year 1998 budget hearings.***

VERA Progress to Date: FY 1996 to FY 2003

VERA has produced favorable results in achieving its goals. Independent reviews by the General Accounting Office (GAO), PricewaterhouseCoopers LLP, AMA Systems, Inc., and the RAND Corporation have validated the VERA methodology as meeting the intent of Congress. These assessments of VERA are discussed in the next section or in Appendix 3.

Table 15 on page 32 shows the impact of FY 1997 – FY 2003 resource allocations by network capped and with VERA adjustments and the capped impact when compared to FY 1996. While the caps and adjustments have ensured VERA was implemented in a manageable fashion, it is important to note that significant amounts of resources have been shifted to networks that were previously under-funded.

The VERA allocation system that was implemented during FY 1997, FY 1998 and FY 1999 limited allocation reductions (excluding equipment and non-recurring maintenance) to a maximum of 5% to ensure that networks who received reduced allocations would have enough time to adjust their financial plans and operations accordingly. Since the start of VERA, the number of networks that received a reduced allocation compared to the prior year, including VERA adjustments and supplements, declined to zero for the fiscal years 2000 to 2003 as shown in Table 13. Networks 13 and 14 were not consolidated until FY 2002 which reduced the total number of networks.

Table 13: Change in Network Allocations over Prior Year Including VERA Adjustments

Fiscal Year	No. of Networks with Increases	No. of Networks with Decreases
1997	17	5
1998	13	9
1999	15	7
2000	22	0
2001	22	0
2002	21	0
2003	21	0

Figure 6 on page 33 shows the results of the full impact of the VERA model for each network capped and with adjustments and supplements.

In four of the seven years under VERA, more than half of the networks received an annual allocation including adjustments that exceeded the system-wide percent increase as shown in Table 14. Networks 13 and 14 were not consolidated until FY 2002.

Table 14: Network Allocations Compared to System-Wide Increase over Prior Year Including VERA Adjustments

Fiscal Year	System-wide % Increase	No. of Networks Above System-wide % Increase	No. of Networks Below System-wide % Increase
1997	2.91	12	10
1998	0.89	11	11
1999	1.33	13	9
2000	9.14	10	12
2001	6.40	13	9
2002	4.86	11	10
2003	9.75	10	11

Table 16 on page 34 and the corresponding Figure 7 on page 35 display the percent change in the allocation for each VERA component from FY 1997 to FY 2003.

Table 15: FY 1996 - FY 2003 Resource Allocations by Network (Capped and with VERA Adjustments)

($ in millions)

Network	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	% Change FY 1996-1997	FY 1997-1998	FY 1998-1999	FY 1999-2000	FY 2000-2001	FY 2001-2002	FY 2002-2003	FY 1996-2003
1 Boston	$854	$845	$809	$785	$821	$895	$943	$1,012	-1.0%	-4.2%	-3.0%	4.6%	9.1%	5.4%	7.3%	18.6%
2 Albany	$437	$434	$416	$411	$460	$495	$507	$556	-0.7%	-4.1%	-1.1%	11.9%	7.5%	2.5%	9.7%	27.4%
3 Bronx	$1,022	$1,017	$974	$952	$974	$995	$1,059	$1,112	-0.5%	-4.2%	-2.3%	2.3%	2.1%	6.4%	5.0%	8.8%
4 Pittsburgh	$775	$779	$779	$790	$862	$940	$956	$1,077	0.5%	0.0%	1.5%	9.1%	9.0%	1.7%	12.6%	38.9%
5 Baltimore	$424	$442	$460	$471	$514	$557	$576	$618	4.2%	4.1%	2.3%	9.1%	8.5%	3.4%	7.3%	45.6%
6 Durham	$682	$707	$704	$716	$788	$843	$882	$991	3.7%	-0.4%	1.8%	10.1%	7.0%	4.6%	12.4%	45.3%
7 Atlanta	$778	$815	$856	$884	$946	$1,011	$1,072	$1,159	4.7%	5.1%	3.3%	6.9%	6.9%	6.1%	8.1%	48.9%
8 Bay Pines	$960	$1,018	$1,071	$1,118	$1,290	$1,354	$1,470	$1,656	6.1%	5.2%	4.5%	15.4%	5.0%	8.5%	12.6%	72.5%
9 Nashville	$688	$700	$704	$710	$772	$805	$849	$927	1.7%	0.6%	0.8%	8.8%	4.3%	5.4%	9.2%	34.6%
10 Cincinnati	$511	$530	$535	$555	$621	$657	$698	$771	3.8%	0.9%	3.7%	11.9%	5.9%	6.1%	10.6%	51.0%
11 Ann Arbor	$655	$657	$632	$656	$695	$753	$766	$849	0.4%	-3.8%	3.8%	6.0%	8.3%	1.7%	10.8%	29.7%
12 Chicago	$834	$828	$795	$781	$831	$878	$899	$978	-0.8%	-4.0%	-1.8%	6.3%	5.7%	2.3%	8.8%	17.2%
15 Kansas City	$585	$616	$616	$608	$640	$676	$718	$761	5.3%	0.1%	-1.4%	5.4%	5.5%	6.2%	6.1%	30.2%
16 Jackson	$1,074	$1,135	$1,194	$1,238	$1,384	$1,431	$1,499	$1,689	5.7%	5.1%	3.7%	11.7%	3.4%	4.8%	12.6%	57.2%
17 Dallas	$587	$623	$652	$654	$744	$792	$850	$937	6.2%	4.7%	0.3%	13.6%	6.4%	7.4%	10.2%	59.7%
18 Phoenix	$485	$518	$545	$567	$683	$713	$732	$803	6.8%	5.1%	4.0%	20.4%	4.5%	2.6%	9.8%	65.5%
19 Denver	$367	$385	$394	$388	$426	$458	$483	$528	4.8%	2.4%	-1.5%	9.9%	7.5%	5.5%	9.4%	44.0%
20 Portland	$584	$622	$652	$677	$760	$798	$840	$903	6.4%	4.9%	3.8%	12.3%	4.9%	5.3%	7.5%	54.5%
21 San Francisco	$688	$720	$733	$749	$821	$893	$948	$1,062	4.7%	1.7%	2.2%	9.6%	8.8%	6.1%	12.1%	54.3%
22 Long Beach	$900	$918	$943	$936	$977	$1,042	$1,083	$1,220	2.0%	2.7%	-0.8%	4.4%	6.7%	3.9%	12.6%	35.5%
23 Minneapolis	$708	$714	$692	$712	$754	$849	$874	$918	0.7%	-3.0%	3.0%	5.8%	12.6%	3.0%	5.0%	29.6%
VHA Total	$14,598	$15,022	$15,157	$15,359	$16,762	$17,835	$18,702	$20,526	2.9%	0.9%	1.3%	9.1%	6.4%	4.9%	9.7%	40.6%

Note: This reflects the impact of VERA with caps, in relation to FY 1996. The 5% low cap through FY 1999 is placed in Basic Vested, Basic Non-Vested, Complex, Research, and Education allocations only. These totals include Equipment and NRM added after the cap is in place. The numbers may not add due to rounding.

FY 1999 Includes VERA plus $20M earmarked by the Congressional Appropriations Conference Committee for Network 3. FY 1999 includes VERA plus adjustments for newly decentralized programs for networks which exceed the 5% limitation. FY 1998, FY 1999, FY 2000 and FY 2001 include supplemental funding adjustments. FY2000 figures have been adjusted to reflect the centralized funding of Prosthetics for FY 2001. FY 2002 includes the final amount allocated with all adjustments. FY 2001 figures have also been adjusted to reflect the rescission ($43M).

Figure 6

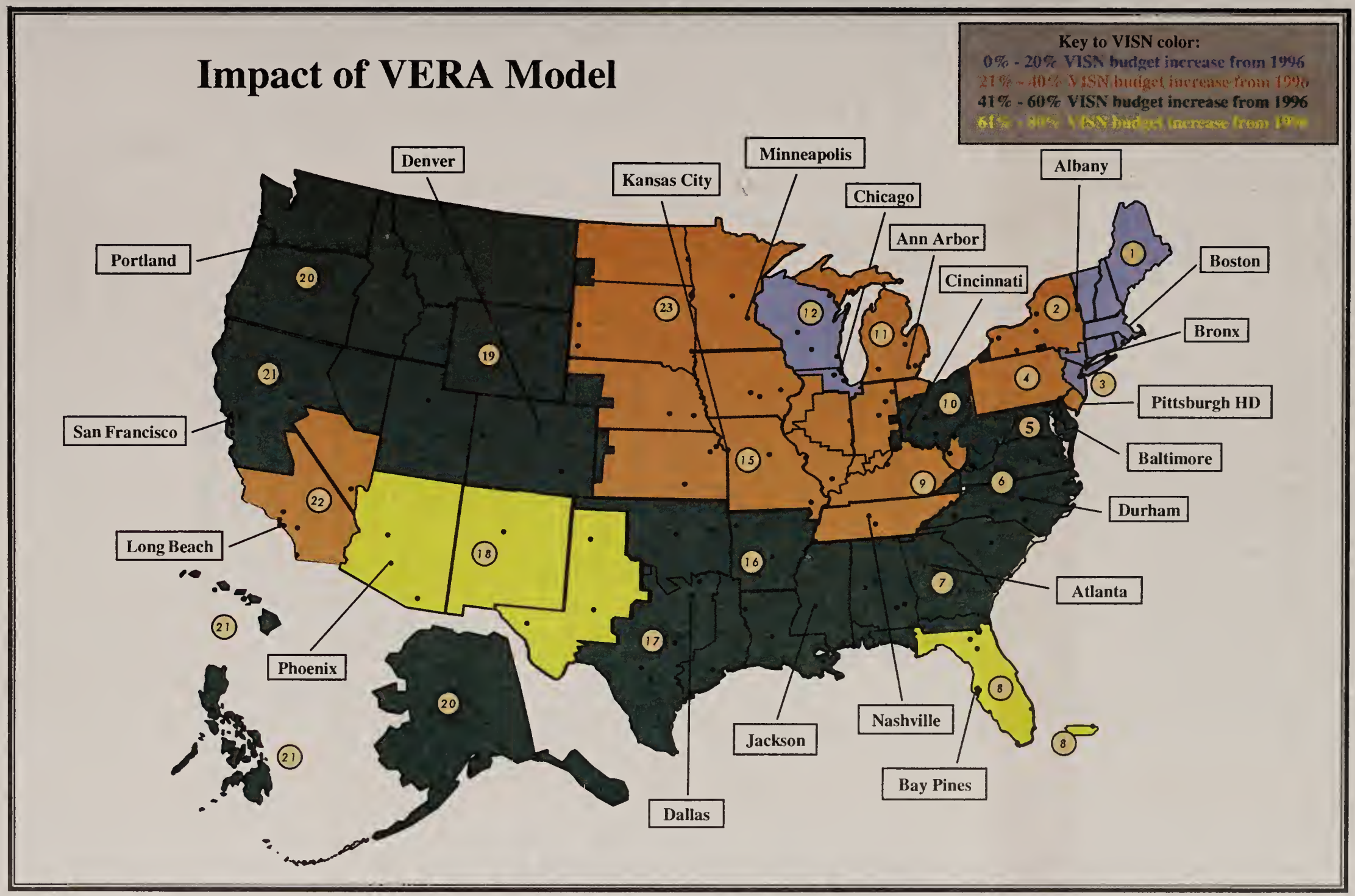

Impact of VERA Model
Key to VISN color:
0% - 20% VISN budget increase from 1996
21% - 40% VISN budget increase from 1996
41% - 60% VISN budget increase from 1996
61% - 80% VISN budget increase from 1996
Denver
Kansas City
Minneapolis
Chicago
Albany
Portland
Ann Arbor
Boston
Cincinnati
Bronx
Pittsburgh HD
San Francisco
Baltimore
Durham
Long Beach
Atlanta
Phoenix
Jackson
Nashville
Bay Pines
Dallas

Table 16 and Figure 7 on page 35 display the percent change in the allocation for each VERA component from FY 1997 to FY 2003. In a number of previous tables and figures, the basis for comparison is FY 1996 to FY 2003, while Table 16 and Figure 7 show a comparison for FY 1997 to FY 2003. Because FY 1997 was the initial year that VA introduced VERA, and the previous resource allocation system did not include the VERA components, the base year for comparison of the percent change in each VERA component begins in FY 1997.

Table 16: Percent Change in Allocation in Each VERA Component, FY 1997 to FY 2003

Network	Basic (Vested & Non Vested)	Complex Care	High Cost Patients	Geo Price Adj	Research Support	Education Support	Equip ment	NRM	Capping	Net FY 1997 FY 2003
1 Boston	21.4	(5.8)	9.7	(0.0)	(0.7)	(0.3)	0.9	(0.3)	(5.0)	19.8
2 Albany	28.9	(3.2)	8.8	(0.4)	(0.5)	(0.5)	1.4	(0.1)	(6.2)	28.3
3 Bronx	14.1	(10.9)	14.9	1.6	(0.5)	(0.2)	0.5	(0.6)	(9.6)	9.3
4 Pittsburgh	37.2	(7.1)	9.1	(0.7)	0.9	(0.2)	1.9	0.1	(2.9)	38.2
5 Baltimore	18.2	7.2	11.5	0.5	1.2	(0.1)	1.3	(0.1)	0.0	39.7
6 Durham	26.4	2.2	9.5	(0.2)	0.3	(0.1)	1.5	0.2	0.6	40.2
7 Atlanta	28.0	(3.4)	9.7	0.2	0.2	(0.2)	1.8	0.2	5.7	42.2
8 Bay Pines	49.9	4.2	7.8	(2.9)	(0.1)	(0.1)	2.7	0.9	0.3	62.6
9 Nashville	31.2	(4.2)	5.7	(0.4)	(0.3)	(0.2)	1.4	0.1	(0.8)	32.4
10 Cincinnati	25.9	8.1	9.7	(0.2)	(0.1)	(0.2)	1.5	0.0	0.6	45.4
11 Ann Arbor	24.7	(4.2)	10.0	(0.3)	(0.2)	(0.1)	1.4	0.1	(2.2)	29.2
12 Chicago	14.2	(1.7)	10.7	1.4	(0.3)	(0.3)	0.6	(0.6)	(5.9)	18.1
15 Kansas City	25.7	(8.8)	5.1	(1.1)	(0.7)	(0.3)	1.3	0.2	2.2	23.7
16 Jackson	30.6	2.5	7.8	0.2	(0.0)	(0.3)	1.8	0.4	5.7	48.7
17 Dallas	30.8	3.3	8.7	(0.7)	0.7	(0.1)	2.0	0.4	5.3	50.3
18 Phoenix	37.4	0.9	6.5	(1.3)	0.5	(0.1)	2.2	0.7	8.2	55.0
19 Denver	27.0	0.7	7.8	0.4	(2.0)	(0.1)	1.6	0.2	1.7	37.4
20 Portland	25.6	0.5	9.3	(0.0)	(0.2)	(0.1)	1.7	0.3	8.1	45.2
21 San Francisco	27.0	(1.3)	12.7	3.6	1.8	(0.0)	1.6	0.7	1.4	47.4
22 Long Beach	21.8	1.1	10.6	0.0	(0.2)	(0.2)	1.5	0.1	(1.9)	32.8
23 Minneaplis	20.8	1.0	6.4	0.1	0.1	(0.2)	0.9	(0.1)	1.9	30.9
VHA Totals	27.1	(1.2)	9.3	0.0	0.0	(0.2)	1.5	0.1	0.0	36.6

Note: The numbers may not add due to rounding.

Figure 7: Percent Change in Allocation in Each VERA Component, FY 1997 to FY 2003

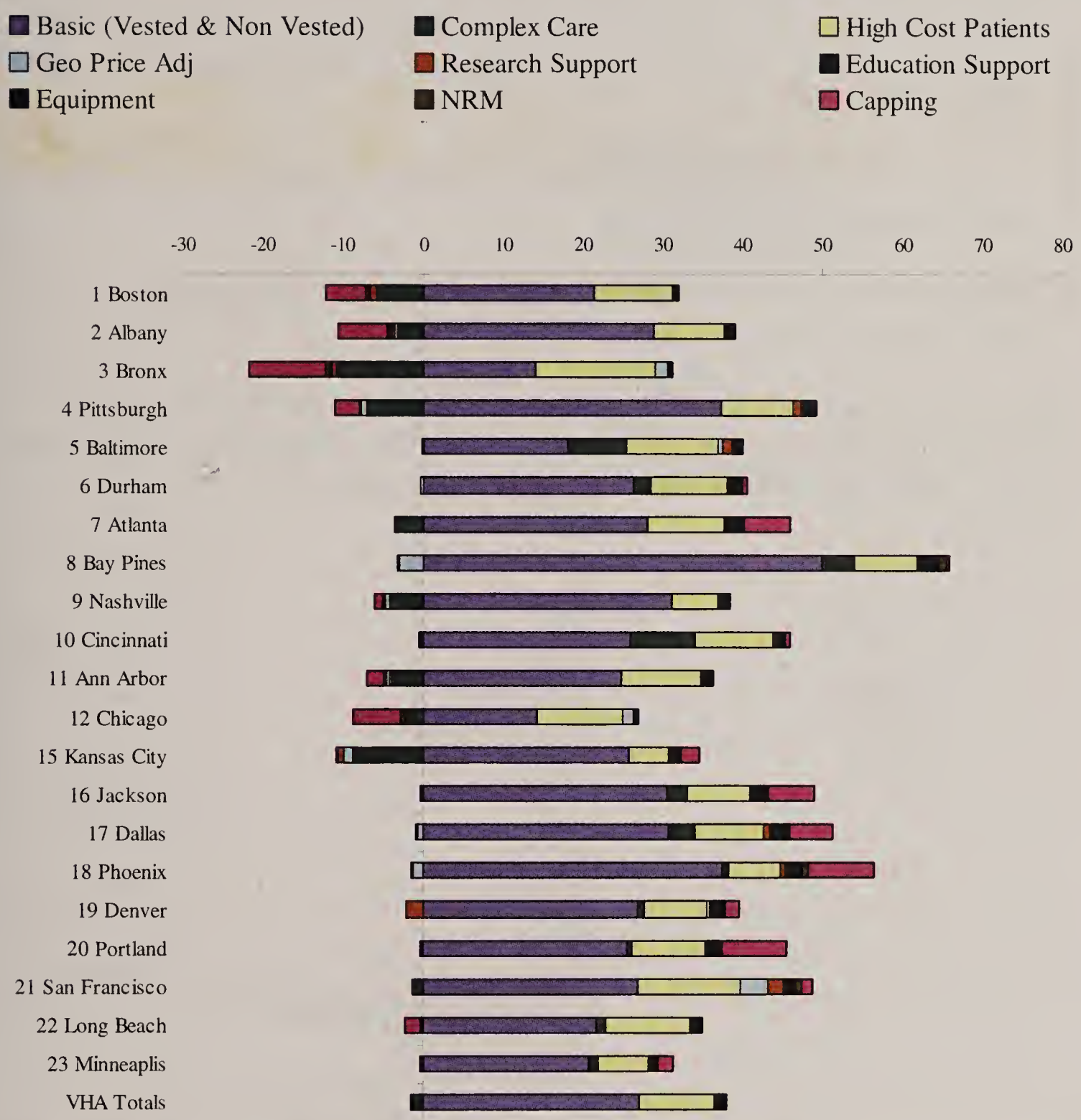


Figure 8 on page 37 depicts the overall result from FY 1996 to FY 2001 on how the VHA allocation was spent. It displays the dollars that are expended by each network, to include the VERA General Purpose allocations, the Specific Purpose allocations and actual collections and reimbursements. The chart shows the percent variance from the national average for each network's total dollars spent

per patient in FYs 1996 – 2001. These changes over time demonstrate that VERA is meeting its objective of funding networks based on their unique needs, not at a single national average rate. There has not been an arbitrary movement of funds to the system-wide mean. The changes are the result primarily of three factors:

1. The network's average projected price per patient (displayed previously in Figure 5 on page 28), which is derived from the network's Basic and Complex Care workload volume, high cost patients, the geographic price adjustment, education support, research support, equipment, non-recurring maintenance and capping adjustments,

2. Recent changes in workload experiences; particularly Basic and Complex Care workload volume,

3. Changes in the level of first and third party collection revenue and reimbursement revenue.

The number of patients treated system wide has increased from 2,936,347 in FY 1996 to 4,149,706 in FY 2001 or by 41.3%. The system wide average dollars spent per patient has decreased by 13.7% from $5,349 in FY 1996 to $4,614 in FY 2001.

Figure 8: FY 1996-FY 2001 Dollars Spent per Patient
Percent Variance from National Average
(FY 2001 is Base Year for FY 2003 VERA Allocation)
(FY 1996 is Base Year before VERA Implementation)

Collections and VERA

Congress enacted provisions in FY 1998 for VA to retain medical collections rather than return them to the Department of Treasury as had been required in the past. The legislation terminated the Medical Care Cost Recovery (MCCR) Fund and, in June 1997, established the Medical Care Collections Fund (MCCF). Since July 1, 1997, all collections from third-party reimbursements, copayments, per diems, and certain torts were deposited in this new fund. Amounts in the MCCF are then transferred to the Medical Care appropriation and remain available until expended. A total of $1.120 billion in collections is projected to be transferred for FY 2003. In addition, a total of $455 million in collections for the Health Services Improvement Fund (HSIF) should be available for networks in FY 2003. Also, a total of $142 million in other reimbursement estimates should be available for networks in FY 2003. These reimbursements include sharing and TRICARE. Public Law 106 – 117, the Veterans Millennium Health Care and Benefits Act, authorized the Secretary to increase the $2 medication copayment, establish a maximum annual and monthly payment applicable to veterans with multiple outpatient prescriptions, revise copayments in outpatient care for "higher-income" veterans, authorizes VHA to receive reimbursements from Department of Defense for certain military retirees using the VA system covered by TRICARE and expands VA's enhanced-use authority. Receipts and collections under the new authority (i.e. the medication copayment increase of $5 from $2 to $7) will be deposited in the Health Services Improvement Fund. The original $2 medication copayment will continue to be deposited in MCCF. Table 17 displays estimated network collections for FY 2003. Table 18 on page 40 depicts the sum of VERA allocations and collections (receipts) for each network.

Table 17: MCCF and Other Collections - FY 2003
($ in millions)

Network	MCCF/HSIF	Sharing/Other
1 Boston	$75	$5
2 Albany	$40	$3
3 Bronx	$83	$5
4 Pittsburgh	$97	$4
5 Baltimore	$41	$3
6 Durham	$96	$5
7 Atlanta	$88	$2
8 Bay Pines	$159	$7
9 Nashville	$80	$7
10 Cincinnati	$44	$4
11 Ann Arbor	$78	$4
12 Chicago	$77	$8
15 Kansas City	$68	$6
16 Jackson	$123	$10
17 Dallas	$59	$18
18 Phoenix	$61	$10
19 Denver	$49	$2
20 Portland	$60	$9
21 San Francisco	$45	$15
22 Long Beach	$48	$7
23 Minneapolis	$104	$8
VHA Totals	$1,575	$142

Note: The numbers may not add due to rounding. These totals do not include national support programs.

Table 18 reflects that the largest percentage increase from FY 2002 in current-year funds available is +15.11% in Network 8, while Network 23 experiences the

smallest percentage increase in total funding with 6.68% when estimated receipts are considered. The minimum any network budget will increase from FY 1996 to FY 2003 is 17.19% in Network 3, while the greatest increase is 89.31% in Network 8.

Table 18: FY 1996 - FY 2003 VERA Allocations with Adjustments and Estimated Receipts

($ in millions)

Network	FY 1996 Allocations and Receipts	FY 1997 VERA and Receipts	FY 1998 VERA and Receipts	FY 1999 VERA and Receipts	FY 2000 VERA and Receipts	FY 2001 VERA and Receipts	FY 2002 VERA and Receipts	FY 2003 VERA and Receipts	% Change FY 1996-1997	FY 1997-1998	FY 1998-1999	FY 1999-2000	FY 2000-2001	FY 2001-2002	FY 2002-2003	FY 1996-2003
1 Boston	$856	$848	$854	$821	$853	$936	$1,006	$1,092	-1.02	0.78	-3.89	3.91	9.72	7.45	8.57	27.52
2 Albany	$438	$435	$441	$431	$478	$516	$536	$599	-0.68	1.32	-2.12	10.81	7.94	3.95	11.67	36.76
3 Bronx	$1,024	$1,019	$1,021	$994	$1,010	$1,038	$1,121	$1,200	-0.48	0.16	-2.61	1.57	2.84	8.00	7.00	17.19
4 Pittsburgh	$776	$781	$819	$828	$901	$988	$1,028	$1,177	0.53	4.85	1.21	8.72	9.71	4.00	14.58	51.64
5 Baltimore	$426	$444	$484	$489	$527	$575	$605	$661	4.21	9.00	1.15	7.74	9.17	5.18	9.19	55.18
6 Durham	$687	$713	$749	$754	$828	$893	$951	$1,092	3.68	5.12	0.67	9.77	7.88	6.43	14.86	58.86
7 Atlanta	$781	$816	$896	$922	$983	$1,057	$1,140	$1,248	4.54	9.83	2.88	6.62	7.49	7.88	9.47	59.87
8 Bay Pines	$962	$1,021	$1,113	$1,161	$1,339	$1,427	$1,583	$1,822	6.06	9.03	4.34	15.34	6.56	10.90	15.11	89.31
9 Nashville	$691	$703	$741	$746	$811	$857	$925	$1,014	1.76	5.37	0.69	8.74	5.58	7.95	9.65	46.72
10 Cincinnati	$513	$533	$558	$574	$639	$682	$736	$819	3.86	4.78	2.95	11.32	6.66	7.94	11.30	59.82
11 Ann Arbor	$656	$659	$665	$687	$726	$794	$828	$931	0.39	0.97	3.36	5.58	9.38	4.33	12.43	41.92
12 Chicago	$839	$832	$840	$820	$868	$928	$973	$1,063	-0.78	0.91	-2.38	5.87	6.95	4.80	9.27	26.74
15 Kansas City	$587	$618	$645	$635	$669	$717	$779	$836	5.25	4.41	-1.56	5.36	7.23	8.69	7.23	42.43
16 Jackson	$1,077	$1,139	$1,245	$1,283	$1,434	$1,497	$1,596	$1,821	5.76	9.30	3.08	11.73	4.39	6.63	14.13	69.13
17 Dallas	$592	$630	$688	$687	$774	$831	$907	$1,014	6.32	9.17	-0.13	12.72	7.39	9.17	11.70	71.12
18 Phoenix	$495	$528	$579	$597	$715	$752	$784	$874	6.58	9.67	3.16	19.64	5.25	4.26	11.51	76.52
19 Denver	$368	$386	$412	$407	$449	$488	$528	$580	4.82	6.79	-1.27	10.28	8.70	8.32	9.87	57.68
20 Portland	$589	$626	$681	$704	$789	$834	$889	$971	6.38	8.64	3.51	11.95	5.73	6.63	9.25	64.94
21 San Francisco	$690	$724	$755	$773	$850	$929	$995	$1,122	4.93	4.29	2.29	10.00	9.35	7.06	12.77	62.56
22 Long Beach	$903	$921	$966	$957	$1,000	$1,076	$1,131	$1,275	2.00	4.88	-0.95	4.51	7.60	5.08	12.75	41.17
23 Minneapolis	$713	$718	$736	$756	$798	$911	$966	$1,031	0.67	2.59	2.65	5.55	14.18	6.05	6.68	44.56
VHA Totals	$14,664	$15,092	$15,886	$16,028	$17,439	$18,726	$20,008	$22,243	2.92	5.27	0.89	8.81	7.38	6.84	11.17	51.68

Note: The FY 1998 MCCF totals include FY 1997 4th quarter collections. The FY 2003 MCCF and Reimbursement figures represent projected collections. The numbers may not add due to rounding.
FY 1999 Includes VERA plus $20M earmarked by the Congressional Appropriations Conference Committee for Network 3. FY 1999 includes VERA plus adjustments for newly decentralized programs for networks which exceed the 5% limitation. FY 1998, FY 1999, FY 2000 and FY 2001 include supplemental funding adjustments. FY 2000 figures have been adjusted to reflect the centralized funding of Prosthetics for FY 2001. FY 2002 includes the VERA adjustments for 4 networks. FY 2001 figures have also been adjusted to reflect the rescission ($43M).

Section III
Assessments of VERA

During the past five years the General Accounting Office (GAO) and a private sector contractor (PricewaterhouseCoopers LLP) have evaluated VERA. Overall, their studies found that VERA is an improvement over previous VA health care funding allocation systems. In fact, PricewaterhouseCoopers LLP concluded that VERA is ahead of other global health care funding systems around the world. The studies recommended changes to strengthen VA's allocation system. Except for the most recent GAO assessment that is discussed below, the recommended changes and VA's actions taken and plans for addressing these recommendations are discussed in Appendix 3.

In addition, in May 1999 VA retained a contractor, AMA Systems, Inc. and its sub-contractor the Center for Naval Analyses Corporation (CNAC), to assess the relative status of patient health care across VA's then 22 networks, and to the extent those differences require disproportionate resource consumption in the affected network that go beyond current VERA adjustments. Early during the course of the study, as a result of increasing concerns from a number of stakeholders, VA amended its evaluation of patient health status contract study to include an analysis of the efficiency of resource allocation to rural areas within the VERA process. The findings, conclusions and recommendations of both studies were completed in July 2000, and are also discussed in Appendix 3.

In FY 2001, the Senate Appropriations Committee directed VA to contract with a Federally Funded Research and Development Center to conduct a VERA study to determine whether VERA's methodology leads to a distribution of funds that covers the special needs of some veterans. Phase I and Phase II of this study were completed and provided to Congress in September 2001 and November 2002 respectively. The findings and recommendations are also discussed in this section.

GAO Evaluation

During FY 2001, Congress asked the GAO to conduct a follow-up VERA evaluation to address the following questions:

- Has the implementation of the VERA methodology resulted in a more equitable allocation of VA health care resources?
- What specific problems are networks and medical facilities experiencing with the VERA methodology?

On February 28, 2002, GAO issued a report entitled *VA Health Care: Allocation Changes Would Better Align Resources with Workload (GAO-02-338).* GAO concluded that VERA is a reasonable approach to allocate resources, but identified weaknesses in its implementation. GAO recommended that VA correct these weaknesses to better allocate comparable resources for comparable workloads.

Based on its findings and conclusions, GAO made the following five recommendations:

- Better align VERA measures of workload with actual workload served regardless of veterans priority group.
- Incorporate more categories into VERA's case-mix adjustment.
- Update VERA's case-mix weights using the best available data on clinical appropriateness and efficiency.
- Determine in the supplemental funding process the extent to which different factors cause networks to need supplemental resources and take action to address limitations in VERA or other factors that may cause budget shortfalls.
- Establish a mechanism in the National Reserve Fund to partially offset the cost of networks' highest cost Complex Care patients.

VA has addressed the five GAO recommendations, which are discussed below:

GAO Recommendation 1:
"Better align VERA measures of workload with actual workload served regardless of veteran priority group."

Based on a careful assessment of all policy options, the Secretary determined not to include certain Priority 7 Basic Care patients in the VERA model for FY 2003. Although the inclusion of non-service-connected Priority 7 veterans in the VERA Basic Care category would be a step toward better aligning the VERA allocation model with VA's actual enrollment experience, including these veterans in the VERA model would create financial incentives to seek out more of these veterans instead of veterans with service-connected disabilities or those with incomes below the current income threshold or special needs patients (e.g., the homeless), veterans who comprise VA's core health care mission.

VA experienced uncontrolled growth in the Priority 7 veterans when they were not included in the VERA model, and VA does not want to encourage unmanageable growth by including them in the VERA model. The allocation of fixed resources to networks is done on a zero sum basis. Increased resources for non-service-connected Priority 7 veterans would come at the expense of veterans who are service-connected, poor, or who require specialized services. The allocation of resources to areas with a disproportionate percentage of non-service-connected

Priority 7 veterans would come at the expense of veterans who live in areas with disproportionately higher numbers of service-connected and lower income veterans.

GAO Recommendation 2:
"Incorporate more categories into VERA's case-mix adjustment."

In FY 2003 the VERA model was refined by substituting the current VERA 3 case-mix model with 10 case-mix categories, including 6 Basic Care price groups and 4 Complex Care price groups, which is a higher grouping of the current 47 patient classifications. VA continues to study the Diagnostic Cost Groups (DCGs), which could potentially be used in the FY 2005 allocation process.

GAO Recommendation 3:
"Update VERA's case-mix weights using the best available data on clinical appropriateness and efficiency."

VA implemented the VERA 10 case-mix category model in FY 2003, which eliminates the need to maintain the FY 1995 Complex Care/Basic Care allocation split of 38% Complex Care and 62% Basic Care. This change updates these weights to reflect the current base year cost experience.

GAO Recommendation 4:
"Determine in the supplemental funding process the extent to which different factors cause networks to need supplemental resources and take action to address limitations in VERA or other factors that may cause budget shortfalls."

In FY 2003 VA implemented caps on the FY 2003 allocation increase over adjusted FY 2002 allocations at the low end of + 5% and at the high end of +12.6%. As a result, it is expected there will be no VERA adjustment or supplemental allocation provided in FY 2003.

GAO Recommendation 5:
"Establish a mechanism in the National Reserve Fund to partially offset the cost of networks' highest cost Complex Care patients."

In FY 2003 VA is providing networks with a VERA adjustment for their top 1% high-cost patients whether in Complex Care or Basic Care. The top 1% high cost adjustment will provide networks with additional funding for patients' costs that exceed a $70,000 threshold.

Federally-Funded Research and Development Center Contractor Evaluation

RAND Corporation Study

Congress directed in Public Law 106-377 that VA enter into a contract with a federally-funded research and development center to conduct an analysis of VERA. VA contracted with the RAND Corporation to conduct this study. In July 2001, RAND submitted its Phase I VERA report to the VHA Office of Finance. In turn, on September 18, 2001, VHA Office of Finance transmitted the Phase I VERA report to Congress.

The FY 2002 Senate Appropriations Committee report language indicated the Committee was pleased with the initial results of the VERA study and directed VHA to continue this federally-funded research and development center study through the end of FY 2002. The RAND Corporation submitted its Phase II VERA report, "An Analysis of Potential Adjustments to the Veterans Equitable Resource Allocation (VERA) System", to VA on October 4, 2002. It was provided to Congress on November 5, 2002. The FY 2003 Senate Appropriations Committee report language further directed VA to continue this federally-funded research and development center study through the end of FY 2003.

RAND's Charge (Phase I): Assess the impact of VERA allocations to VISNs with respect to the following three specific areas of concern expressed by Congress:

- The impact of the allocation of funds under the VERA formula on VISNs and sub-regions with older-than-average medical facilities; those with older or more disabled enrolled veterans; those undergoing major consolidation; and/or those with appointment backlogs and waiting periods in rural and urban sub-regions.
- Issues associated with the maintenance of direct affiliations between VA medical centers and university teaching and research hospitals.
- Whether the VERA formula for allocating funds adequately accounts for differences in weather conditions when calculating the cost of construction and maintenance of health care facilities and whether VISNs that experience harsh weather conditions require more resources.

To address these issues within the project's allotted time frame, RAND initially conducted a qualitative analysis of the VERA system gathering data from site visits, interviews, and published reports. Findings from that analysis appear in a report entitled "An Analysis of the Veterans Equitable Resource Allocation (VERA) System" (RAND MR-1419-DVA).

The Phase I report identified several key issues that would require additional quantitative evaluation to resolve; however, such analysis was outside the scope of that initial phase of work. As a result, in the fall of 2001, Congress directed VA to continue the federally-funded research and development center study through FY 2002. VA contracted with RAND to conduct a Phase II VERA study.

An underlying concern in Phase I, and one that was articulated in the legislation calling for the study, was whether the VERA system for allocating resources omitted consideration of certain factors, particularly factors that had a predictable and systematic impact on the costs of providing health care to veterans and were largely outside the control of VISN directors. The goal of the Phase II VERA study was intended to evaluate the impact of these factors on the variation in individual patient costs across VISNs and to assess the potential effects of modifications that might be made to VERA for such factors.

With regard to the three critical issues identified by Congress, the initial RAND Phase I study concluded the following:

- Overall, the study identified factors that may influence the costs of, and access to, care within the VA system and assessed how VERA adjusts for those effects. Among the findings of the report was that health care delivery costs might be affected by the age, physical condition, and historical significance of a VISN's facilities, factors for which VERA makes no adjustments.
- Another finding was that VERA's case-mix adjustment methodology might not account adequately for differences in the average health status of veterans across VISNs. In contrast, the influence of such factors as weather extremes and rural versus urban location appeared less clear. Finally, the report concluded that a comprehensive evaluation of the current system, as well as the potential effects of modifications to it, would require extensive, quantitative analysis.

RAND's charge for Phase II was to evaluate the impact of the Phase I findings on the variation in individual patient costs across VISNs and to assess the potential effects of modifications that might be made to VERA for such factors. The Phase II objectives were to:

- Quantify the impact of patient, facility, and environmental variables on costs
- Focus on concerns expressed in original legislation
- Create a tool to assess the impact of a wide range of policy changes
- Simulate how policy changes would affect VISN allocations

RAND analyzed data from a variety of sources including VA, the Centers for Medicare and Medicaid Services, and individual counties nationwide, and

evaluated the effects of 17 individual and 22 facility characteristics on the variation in individual patient costs across VISNs. Two models were constructed to account for factors that affected patient costs. The first, referred to as the "fully specified model," included all sociodemographic and health status variables previously found to influence health care costs as well as a number of factors specified by Congress. The second model, referred to as the "policy model," was constructed by excluding from the fully specified model any variables that did not meet current VA policy objectives as well as those related to efficiency considerations.

Estimates from the regression equations were used to predict patient level costs, which were then aggregated to the VISN level to allow cross-VISN comparisons. The models were used to simulate the potential influence on VISN allocations of varying patient and facility characteristics. RAND also assessed the influence of alternative case-mix adjustments, and tested the sensitivity of the results to the method used to allocate costs to patients and to the inclusion of Priority 7 patients.

The major findings of Phase II are summarized as follows:

- The current VERA system for allocating resources to VISNs does not account for a number of measurable factors that affect patient care costs, including patient and facility characteristics that vary systematically across VISNs and that are largely beyond VISN directors' control. Alternative methods for allocating resources to VISNs, based on the principles that guide VERA but that better account for these factors, may produce a more equitable allocation system.
- Case-mix measures play a key role in explaining patient-level cost differences. Overall, more-detailed case-mix measures accounted for more of the variation in individual patient care costs than less-detailed measures. All three alternatives examined had significantly more explanatory power than the method currently used in VERA.
- Age and sex independently affect patient care costs, controlling for alternative case-mix measures and other factors.
- The degree to which VA patients rely on Medicare providers for the care they receive has a significant impact on VA costs. As one might expect, patients who are more reliant on Medicare providers incur lower VA costs vis-à-vis those patients who receive little or no care from Medicare providers.
- Veterans who live in urban and suburban areas use more resources than those who reside in rural areas. At the same time, costs are higher for those veterans who must travel longer distances for care.
- Most facility infrastructure characteristics – including age, historical significance, total building count, and average physical condition – do not appear to have a significant independent effect on patient care costs.

However, both the number of square feet of building space per patient (a measure of building capacity and the extent to which it is being used efficiently) and per acre of land (a measure of the density of the infrastructure) increased facility costs.

- The choice of case-mix measure and the other factors included in the RAND policy model influence whether teaching is an important factor in explaining patient care costs. Teaching intensity is a significant factor only with the VA DCGs, where it has a negative effect on facility costs (facility costs decrease as the ratio of residents-to-physicians increases).
- Research intensity (measured by the research costs per unique patient) has a positive effect on facility costs.
- In comparing the simulation results to actual FY 2002 allocations, it was found that for the RAND base case simulation – in which the regression methodology was applied and controlled for the same set of factors that VA currently controls for in the current VERA model – $282 million, or 1.5 percent of the total appropriation, would be redistributed across the VISNs.
- The total amount of money that is redistributed by the VERA-3 policy model (which controls for additional factors) relative to the base case is $434 million, or 2.4 percent of the total appropriation.
- The choice of a case-mix measure has a substantial impact on VISN allocations. Each of the three alternative case-mix measures examined (VERA-10, VERA-47, and VA DCGs) would result in substantial movement of budget allocations across VISNs. The magnitude of the budget reallocation (relative to VERA-3) is sensitive to the choice of an alternative case-mix measure. For some VISNs, the direction of the budget reallocation also varies by case-mix measure (i.e., some VISNs would gain if VA shifted to VERA-10, but those same VISNs would lose if VA shifted to VA DCGs). However, this shift in direction occurs only in cases where the gain or loss is relatively small.
- The results from the comparisons between the VERA-3 policy model and policy models with the other case-mix measures illustrate that the movement from VERA-3 to VA DCGs redistributes substantially more money than would the movement to either VERA-10 or VERA-47. At the national level, the move to VA DCGs would redistribute 1.9 percent of the total appropriation compared to approximately 1 percent under VERA-10 and VERA-47.
- The results were relatively insensitive to several methodological factors: the method used to allocate costs to patients (for the alternative cost methods examined); whether or not the Basic Care Priority 7 patients (those Priority 7 patients not currently credited in VERA) were included in the patient and facility regression equations; and the year of data used to estimate the models.

- When the Basic Care Priority 7 veterans are included in the simulations, approximately half of the VISNs received larger simulated allocations and half received smaller allocations, compared to the simulated allocations based on policy models that excluded these patients (but included Complex Care Priority 7 veterans only).

In light of the findings of the Phase II VERA study, the RAND Corporation believes that VA should consider modifying VERA. The Phase II VERA study generated the following conclusions:

Patient and Facility Characteristics: VA should consider modifying VERA to take greater account of patient and facility characteristics than it does now. Movement in this direction would retain most of the strengths of VERA while increasing the alignment between VISN allocations and patient workloads. Specifically, VERA should expand the number of adjustments that it currently makes to account for the patient-level and facility-level variables included in the policy model. To make these adjustments, VA should consider adopting an allocation system that relies on a regression/simulation framework similar to the one used in the Phase II analysis. However, before making any modifications along these lines, during Phase III of the study, VA should:

- Better understand how particular variables influence VISN allocations
- Refine the models to reflect more recent data
- Resolve the following key implementation issues:

    1. Educate all relevant stakeholders on the pros and cons of adopting the regression-based allocation framework
    2. Make "prices" explicit
    3. Improve facility-level data collection and reporting processes

Case-mix Adjustment: RAND proposes that VERA should take greater account of case-mix differences across facilities and VISNs than is now possible within the three-category case-mix system (i.e., Basic Vested, Basic Non-Vested, and Complex Care) on which VERA is currently based.

Among the four alternative case-mix systems considered (VERA-3, VERA-10, VERA-47, and VA DCGs), pending the outcome of Phase III, potential modifications could include:

- Using either the VERA-10 or the VA DCGs case-mix measures

    - If a more refined case-mix adjustment is made, the educational support component of VERA should be revisited

While VERA-47 represents an improvement over VERA-3 in the amount of patient cost variation explained, VERA-47 provides only a small improvement over VERA-10 while introducing considerably more complexity into the allocation system.

The choice between VERA-10 and VA DCGs involves some trade-offs. VA DCGs have greater explanatory power in comparison to the VERA-10 case-mix measure; and they are less likely to create an incentive to increase length of stay or to steer patients toward inpatient rather than outpatient care, because they are not based on patient utilization. However, DCGs are also less transparent than are the VERA-10 groups and would probably be more difficult to administer, at least in the short run.

RAND suggests that in the event VA decides to implement a DCG-based system, that VA continue to explore refinements to that system, particularly with respect to inpatient mental health and long-term care. RAND also suggests that additional research is needed to help identify the reasons why some VISNs would experience a positive reallocation under VERA-10, relative to VERA-3, and a negative reallocation under VA DCGs, or vice versa.

The study provided additional explicit conclusions:

Academic Affiliations: The current method of funding education and research support costs through separate allocations should be reconsidered if the allocation process is modified to include more refined case-mix measures and/or a broader set of individual and facility characteristics.

Medicare Reliance: VERA should be modified to account for differences in the degree to which VA patients rely on Medicare providers for the care they receive. Although accounting for Medicare reliance will undoubtedly increase the system's complexity, it will also make the system more equitable. Accounting for Medicare reliance might also help mitigate the potential for VISNs to receive additional revenue for treating patients who receive the bulk of their care through Medicare providers, in the event that VA adopted a case-mix measure, such as DCGs, that assigned patients to cost categories based solely on diagnoses.

Other Variables: Other than the case-mix variables, the variables in the individual-level policy model (e.g., age, sex, urban/rural location, Medicare reliance, Medicaid long-term care generosity) add little incremental explanatory power, once case-mix is accounted for. However, these non-case-mix variables are statistically significant. There are sound conceptual reasons for including them in the model; and they have a substantial impact on the simulated allocations.

Basic Care Priority 7 Patients: An issue of ongoing interest to VA, veterans groups, and the Congress is whether Basic Care Priority 7 patients should be included in workload calculations. When addressing this issue, decision makers must assess how patient care resources would be redistributed across priority groups, how the economic incentives facing VISN directors and facility managers would be altered, how waiting times and appointment backlogs might be affected, and possibly even how the quality of care offered to veterans could change. Such assessments would become especially crucial if a decision to include the Basic Care Priority 7 patients were not accompanied by a larger medical care appropriation and/or enrollment reforms.

RAND believes that if VA decided to include Basic Care Priority 7 patients in workload calculations, then some VISNs would gain revenue at the expense of other VISNs, assuming that Congress does not increase the medical care appropriation to take greater account of the costs of treating those patients.

Other Issues: RAND believes that in addition to generating important insights into factors that influence the costs of providing care to the veteran population, with an emphasis on those factors expressed by Congress in the legislation mandating this study, the regression/simulation modeling approach provides VA policymakers with a valuable tool for making resource allocation decisions. Apart from using the model to simulate VISN allocations under various policies, it can also be used by VISN directors in making allocations to facilities and by VA headquarters staff in the allocation adjustment, or supplemental process.

To maintain the policy relevance of the model, it is recommended that VA refine the model on an ongoing basis. Two possible refinements would include incorporating more recent VA and Medicare data, as they become available and incorporating quality and access measures as well.

To preserve VA's objective of allocating resources in as equitable and simplistic a manner as possible, additional analyses are required to better understand why various adjustments lead to relatively large swings in VISN allocations and to explicate more clearly the set of "prices" that each VISN will face for treating different types of patients. Over the next year, RAND staff will be working with VA to refine the model and to generate insight into the impact of controlling for additional variables on VISN allocations.

Study Limitations: In reviewing RAND's findings, the following study limitations should be considered:

- The facility-level data set, with just 143 observations, was quite small compared to the patient-level data set of nearly four million patient records.

The small number of facility observations may have limited RAND's ability to detect particular effects.

- Although the analysis generated insight into factors that explain variation in patient-level costs, RAND was unable to compare, for example, the average cost per patient to any sort of efficiency "gold standard." In other words, RAND had no way of knowing what the "right" costs should be for any given patient. Rather, RAND was able to compare only how costs vary for patients and facilities with different characteristics. This problem is exacerbated by the fact that the necessary data are not available to adjust cost data to reflect differences in quality of care across facilities and VISNs.
- The validity of RAND's analysis ultimately depends to a great extent on the completeness and quality of the data that were used to construct the patient and facility equations. In general, RAND found the patient-level data to be quite complete, with the exception of certain variables such as income. While RAND did not attempt to validate a sample of the patient data against data drawn from patients' medical records, they did conduct a variety of reliability and validation checks using data from multiple years on the same set of patients. From what could be determined, the patient level data appeared to be of very high quality.
- If VA chooses to adopt an allocation methodology that accounts for facility-level characteristics, such as RAND's regression/simulation approach, the quality of the facility data collection process should be improved. Specifically, the definition of what constitutes a facility should be developed (e.g., a management unit or physical location) and applied consistently throughout the data collection process.

VA has shared this study widely both internally and externally to include, Network Directors, VA and VHA Central Office Officials, VHA National Leadership Board Finance Committee, the Senate Appropriations Committee (Chairman and Ranking Member), and the House Appropriations Committee (Chairman and Ranking Member).

Section IV
The Future of VERA

Based on the GAO and PricewaterhouseCoopers LLP evaluations, as well as VA's own internal assessments of VERA, there are two areas that are currently under review for potential changes to VERA in FY 2005 and beyond.

Patient Classification

During FY 2003, the National Leadership Board (NLB) Finance Committee will continue to review future VERA methodology changes, e.g., Diagnostic Cost Groups (DCGs), for potential application in FY 2005. Over the past several years, the use of DCGs and risk adjusters have been studied by the VHA Houston Center for Quality of Care and Utilization Studies, a VA Health Services Research and Development (HSR&D) Center for Excellence and the VHA Management Science Group in Bedford, Massachusetts, currently for the NLB Finance Committee and previously the VERA Patient Classification Workgroup. The VA–DCG model is similar to the one used by the Centers for Medicare and Medicaid Services (CMS) for its Medicare + Choice program and is a case-mix model that is based mainly on diagnosis and demographics of patients, except in the case of special needs Complex Care patients, where case-mix is based on utilization factors similar to the VERA model. The DCG model, ICD-9-CM Diagnostic Codes are used to produce 545 diagnostic groups that are further classified into 118 Hierarchical Condition Categories (HCCs). For allocation purposes, patients are then grouped based on their predicted expenditures into Diagnostic Cost Groups. The DCGs for VA purposes contain 25 case-mix categories (only 24 cost groups). The Houston Center for Quality of Care and Utilization Studies and the Management Science Group have developed modifications to the current DCG system using actual VA cost data. If the NLB Finance Committee review demonstrates identifiable benefits, a DCG or modified DCG system could be considered for the FY 2005 allocation process.

RAND Corporation Study

The FY 2003 Senate Appropriations Committee report language has directed a Phase III RAND VERA study that will provide analyses analogous to the ones in Phase II, using the most recent VA and Medicare data. Further, in Phase III, RAND will provide the results of disaggregating the data to allow the examination of VISN allocations by selected patient and facility level variables. The Senate Appropriations Committee directed VA to provide interim reports on Phase III in February 2003 and June 2003 and a complete study by the end of FY 2003.

APPENDICES

Appendix 1: Key formulas and data in the FY 2003 VERA

Appendix 2: The Veterans Integrated Service Networks

Appendix 3: History: Previous Allocation Models, Changes to VERA, Results, VERA Supplemental Adjustments and Previous Assessments

Appendix 1

Key Formulas and Data in the FY 2003 VERA

Key formulas and data in the FY 2003 VERA

Allocation factors	Total dollars allocated	Mechanism to determine total dollars	Definitions of workload (unit of measure)	National total workload (unit of measure)	National Price/allocation rate
Basic Care (Sum of 6 Basic Care Price Groups)	$12,478,652,268	67.2% of Basic Care and Complex Care dollars available. The Basic Care and Complex Care dollars are the total General Purpose (GP) funding less the funding for Research Support, Education Support, Equipment and Non-Recurring Maintenance (NRM). The percentage for each group is updated based on FY 2001 DSS cost experience.	Number of patients in the 3 year Cat A/X user file. Three year file includes FYs 1999, 2000, and 2001 patients who rely on VA for their care. There are 6 Basic Care Price Groups, and each includes VERA Patient Classes described below. Workload units based on historical utilization are adjusted to reflect care provided in more than one network.	3,779,887	**Each of the 6 Basic Care Price Groups has a separate price based on the dollars allocated divided by the total workload**
1. Non-Reliant Care	$116,547,124	0.62% of Basic Care and Complex Care dollars, less the High Cost Payments of $923,491.	This group includes 4 Patient Classes: 1) Employee/Collaterals; 2) Pharmacy; 3) Compensation and Pension Exams; and 4) Non-Vested Patients. The FY 2001 patient workload in the Employee/Collaterals and Pharmacy classes are only included under the VERA methodology in conjunction with care delivered to that veteran in other classes.	443,477	**$263 per Non-Reliant Care Basic Care Workload Unit**
2. Basic Medical	$4,169,216,455	22.20% of Basic Care and Complex Care dollars, less the High Cost Payments of $35,298,984.	This group includes 5 Patient Classes: 5) Ear, Nose, and Throat; 6) Other Acute Diseases; 7) Endocrine, Nutritional and Metabolic Disorders; 8) Central Nervous System, and 9) Musculoskeletal Disorders.	1,727,650	**$2,413 per Basic Medical Basic Care Workload Unit**
3. Mental Health	$1,076,150,278	5.71% of Basic Care and Complex Care dollars, less the High Cost Payments of $4,988,266.	This group includes 2 Patient Classes: 10) Acute Mental Disease, and 11) Addictive Disorders.	302,092	**$3,562 per Mental Health Basic Care Workload Unit**
4. Heart/Lung/ GI	$2,910,016,343	15.69% of Basic Care and Complex Care dollars, less the High Cost Payments of $61,573,577.	This group includes 3 Patient Classes: 12) Cardiovascular Disease, 13) Gastroenterology Disorder; and 14) Pulmonary Disease.	781,904	**$3,722 per Heart/Lung/GI Basic Care Workload Unit**
5. Oncology	$889,650,052	4.87% of Basic Care and Complex Care dollars, less the High Cost Payments of $32,159,501.	This group includes 3 Patient Classes: 15) Hepatitis C without Anti-viral Therapy; 16) HIV without Anti-retroviral Therapy; and 17) Oncology.	106,711	**$8,337 per Onocology/Infectious Disease Basic Care Workload Unit**
6. Multiple Problem	$3,317,072,016	18.14% of Basic Care and Complex Care dollars, less the High Cost Payments of $117,579,579.	This group includes 4 Patient Classes: 18) Medical Psychiatric + Substance Abuse; 19) Psychiatric + Substance Abuse; 20) Multiple Medical; and 21) Post Traumatic Stress Disorder (PTSD) Acute.	418,053	**$7,935 per Multiple Medical Basic Care Workload Unit**
Subtotal	**$12,478,652,268**				

Key formulas and data in the FY 2003 VERA

Allocation factors	Total dollars allocated	Mechanism to determine total dollars	Definitions of workload (unit of measure)	National total workload (unit of measure)	National Price/allocation rate
Complex Care (Sum of 4 Complex Care Price Groups)	$5,063,193,869	32.8% of Basic Care and Complex Care dollars available. The Basic and Complex Care dollars are the total GP funding less the funding for Research Support, Education Support, Equipment and NRM. The percentage for each group is updated based on FY 2001 cost experience.	Number of Complex Care patients forecasted to use the VISN in FY 2003. This one year forecasted number is based on historical utilization over five years (FYs 1997-2001). Workload units based on historical utilization are adjusted to reflect care provided in more than one Network. The forecast continues to include a factor for age, but no longer for veteran population trends.	155,739	**Each of the 4 Complex Care Price Groups has a separate price based on the dollars allocated divided by the total workload**
7. Specialized Care	$926,779,306	5.31% of Basic Care and Complex Care dollars, less the High Cost Payments of $79,204,283.	This group includes 5 Patient Classes: 22) Hepatitis C with Anti-viral Therapy; 23) HIV+ with Anti-retroviral Therapy; 24) Post Traumatic Stress Disorder (PTSD) Chronic; 25) Home Based Primary Care (HBPC); and 26) Traumatic Brain Injury (TBI).	49,425	**$18,751 per Specialized Care Complex Care Workload Unit**
8. Supportive Care	$1,703,614,118	10.63% of Basic Care and Complex Care dollars, less the High Cost Payments of $309,408,035.	This group includes 7 Patient Classes: 27) Stroke; 28) Domiciliary; 29) Spinal Cord Injury (SCI) Parapelegic - Old Injury; 30) SCI Quadrapelegic - Old Injury; 31) Blind Rehabilitation; 32) Community Nursing Home; and 33) Long Term Care (LTC): Low Activities of Daily Living (ADL).	57,207	**$29,780 per Supportive Care Complex Care Workload Unit**
9. Chronic Mental Illness	$1,037,311,095	6.55% of Basic Care and Complex Care dollars, less the High Cost Payments of $202,527,713.	This group includes 4 Patient Classes: 34) Mental Health Intensive Case Management; 35) Other Psychosis; 36) Substance Abuse; and 37) Schizophrenia and Dementia.	26,296	**$39,448 per Chronic Mental Illness Complex Care Workload Unit**
10. Critically Ill	$1,395,489,350	10.28% of Basic Care and Complex Care dollars, less the High Cost Payments of $551,471,434.	This group includes 10 Patient Classes: 38) End Stage Renal Disease (ESRD); 39) SCI Parapelegic - New Injury; 40) SCI Quadrapelegic - New Injury; 41) LTC: Clinical Complex; 42) LTC: Behavioral; 43) LTC: Physical; 44) LTC: Rehabilitation; 45) LTC: Specialized Care; 46) Transplants; and 47) Ventilator Dependent.	22,811	**$61,177 per Critically Ill Complex Care Workload Unit**
Subtotal	**$5,063,193,869**				

Key formulas and data in the FY 2003 VERA

Allocation factors	Total dollars allocated	Mechanism to determine total dollars	Definitions of workload (unit of measure)	National total workload (unit of measure)	National Price/allocation rate
High Cost Patient Funding	$1,395,134,863	Patient costs that exceed $70,000 (1% High-Cost Patients) are removed from the pool of funds for each of the 10 Price Groups.	Networks receive an additional allocation equal to the amount that these costs exceeded the $70,000 threshold.	29,928	**An average of $40,815 for Basic Care Patients and $48,128 for Complex Care Patients nationally**
Geographic Price Adjustment	$0	The Geographic Price Adjustment (labor index), is applied against $14.05 billion labor, contractual labor and non-labor contractual goods dollars expended in FY 2001, which is approximately 66% of FY 2001 total obligations.	The FY 2003 VERA labor index is computed using 4 pay periods of FY 2001 normal pay data only and a national market basket methodology. The adjustment continues (as began in FY 2002) to account for local cost of living factors associated with procuring contracted labor and non-labor contractual goods such as energy related products, utilities and provisions. For FY 2003, the labor index methodology for computing is unchanged.		
Research support	$400,375,000	Total of research support funds in the FY 2003 President's budget	Dollars of FY 2001 funded research (intra- and extra-mural research). Applies weights: 100% for VA administered research; 75% for peer reviewed research which is not VA administered; 25% for non-peer reviewed research which is not VA administered.	$881,818,194 unweighted; $740,057,493 weighted	**$0.54 per dollar of Reported Research**
Education support	$355,599,000	Total of education support funds in the FY 2003 President's budget	Number of residents for Academic Year 2002/2003.	8,787	**$40,469 per Resident**
Subtotal	**$2,151,108,863**				

Key formulas and data in the FY 2003 VERA

Allocation factors	Total dollars allocated	Mechanism to determine total dollars	Definitions of workload (Unit of measure)	National total workload (unit of measure)	National Price/allocation rate
Equipment - capitation	$577,708,000	Total of equipment funds in the FY 2003 President's budget	The Equipment allocation is based totally on PRP workload (Sum of Basic Care (6 price groups) and Complex Care (4 price groups) workload).	3,935,626	**$147**
NRM -Boeckh Index times total workload NEW MODEL	$254,865,000	Derived from non-recurring maintance funds in the FY 2003 President's budget	The NRM allocation is based on workload adjusted by the Boeckh Index (Workload (PRPs) times Boeckh Index). This Boeckh Index is an external inflation index that measures the relative cost of building and/or renovating space.	74,365	**$3,427**
Total Capital Accounts	**$832,573,000**	**Derived from FY 2003 President's budget**			
VERA Capping	**$0**	Network allocations are adjusted to assure all have a gain over FY 2002 of at least 5%. Allocations for networks with largest gains from FY 2002 are adjusted to a maximum of 12.6% to fund the increases of networks up to the 5% level.	Networks receiving an increase or decreased adjustments (dollars in thousands): Network 3 (+$38,171); Network 4 (-$6,352); Network 8 (-$32,580); Network 16 (-$510); Network 22 (-$12,170); and Network 23 (+$13,440).		
Total $ General Purpose	**$20,525,528,000**	Derived from FY 2003 Medical Care budget less Specific Purpose funding			

Basic Care and Complex Care Workload in each of the 10 Price Groups FY 2003

	Basic Care							Complex Care					
Network	1 Non Reliant including Non Vested	2 Basic Medical	3 Mental Health	4 Heart and Lung	5 Oncology	6 Multiple Problem	Basic Care Total	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	Complex Care Total	Total
1 Boston	15,969	73,788	16,233	36,261	4,322	21,605	168,178	1,799	2,391	1,741	998	6,930	175,109
2 Albany	13,214	44,981	7,747	23,430	2,261	11,090	102,723	2,080	1,351	1,043	580	5,054	107,777
3 Bronx	17,372	70,429	12,522	31,034	5,557	19,001	155,915	3,518	1,749	1,837	1,061	8,164	164,079
4 Pittsburgh	31,977	90,216	16,717	47,067	5,126	20,429	211,533	2,215	2,242	1,621	1,716	7,795	219,327
5 Baltimore	14,883	42,947	7,106	20,670	2,932	11,415	99,953	1,893	1,957	989	741	5,579	105,532
6 Durham	20,331	83,057	14,721	41,257	4,884	20,277	184,527	2,481	2,740	1,018	1,535	7,773	192,300
7 Atlanta	25,482	105,581	17,862	48,369	5,752	21,834	224,880	3,335	3,716	1,237	1,104	9,392	234,272
8 Bay Pines	28,849	160,614	25,340	71,859	10,274	40,874	337,811	4,559	5,935	974	1,707	13,176	350,987
9 Nashville	20,506	85,207	14,065	40,802	5,222	20,977	186,779	1,490	3,080	927	889	6,386	193,165
10 Cincinnati	15,522	57,941	14,159	29,367	3,433	13,170	133,592	2,489	1,936	1,642	1,021	7,088	140,680
11 Ann Arbor	17,503	67,486	13,848	35,493	3,800	17,971	156,100	1,931	1,883	1,124	958	5,895	161,995
12 Chicago	17,926	65,523	11,063	30,233	4,105	19,336	148,186	2,069	3,177	1,835	1,308	8,390	156,576
15 Kansas City	16,145	69,495	12,206	34,722	4,520	16,675	153,763	1,760	2,226	1,126	592	5,704	159,466
16 Jackson	34,607	161,630	26,871	74,313	10,392	35,227	343,040	3,481	4,363	1,785	1,551	11,180	354,220
17 Dallas	24,941	88,506	12,071	32,548	4,335	19,761	182,163	1,686	3,068	1,375	1,333	7,462	189,625
18 Phoenix	16,209	82,867	11,577	36,016	4,693	17,817	169,178	1,857	2,479	432	773	5,541	174,719
19 Denver	12,660	50,518	8,256	19,991	2,873	11,503	105,801	1,417	1,273	696	435	3,821	109,622
20 Portland	24,249	75,966	15,967	28,602	4,649	17,996	167,429	1,945	3,298	1,343	754	7,340	174,769
21 San Francisco	23,050	76,201	14,004	31,598	6,489	17,764	169,105	2,563	2,350	1,054	1,170	7,137	176,242
22 Long Beach	28,972	98,384	17,936	34,293	6,895	24,986	211,466	2,611	3,422	1,374	1,201	8,608	220,074
23 Minneapolis	23,108	76,312	11,823	33,979	4,198	18,346	167,766	2,246	2,575	1,121	1,382	7,325	175,091
VHA Totals	443,477	1,727,650	302,092	781,904	106,711	418,053	3,779,887	49,425	57,207	26,296	22,811	155,739	3,935,626

Note: Numbers may not add due to rounding.

Basic Care: Back-up data FY 1997 to FY 2003

Network	FY 1997 VERA	FY 1998 VERA	FY 1999 VERA	FY 2000 VERA	FY 2001 VERA	FY 2002 VERA	FY 2003 VERA	Difference FY 1997 - FY 1998	Difference FY 1998 - FY 1999	Difference FY 1999 - FY 2000	Difference FY 2000 - FY 2001	Difference FY 2001 - FY 2002	Difference FY 2002 - FY 2003	% Change FY 1997 - FY 1998	% Change FY 1998 - FY 1999	% Change FY 1999 - FY 2000	% Change FY 2000 - FY 2001	% Change FY 2001 - FY 2002	% Change FY 2002 - FY 2003	% Change FY 1997 - FY 2003
1 Boston	154,885	155,917	159,727	164,241	165,114	162,737	168,178	1,032	3,809	4,514	874	-2,377	5,441	0.7%	2.4%	2.8%	0.5%	-1.4%	3.3%	8.6%
2 Albany	80,230	80,577	83,851	91,751	96,943	98,983	102,723	347	3,274	7,900	5,191	2,040	3,740	0.4%	4.1%	9.4%	5.7%	2.1%	3.8%	28.0%
3 Bronx	149,736	147,502	149,028	162,857	165,292	160,586	155,915	-2,234	1,526	13,829	2,435	-4,706	-4,672	-1.5%	1.0%	9.3%	1.5%	-2.8%	-2.9%	4.1%
4 Pittsburgh	144,747	150,922	171,218	192,583	205,413	205,983	211,533	6,175	20,296	21,365	12,830	570	5,549	4.3%	13.4%	12.5%	6.7%	0.3%	2.7%	46.1%
5 Baltimore	94,150	94,327	95,044	96,478	97,126	96,695	99,953	177	717	1,434	648	-431	3,258	0.2%	0.8%	1.5%	0.7%	-0.4%	3.4%	6.2%
6 Durham	164,500	165,619	169,581	177,160	178,267	177,597	184,527	1,119	3,962	7,578	1,108	-670	6,929	0.7%	2.4%	4.5%	0.6%	-0.4%	3.9%	12.2%
7 Atlanta	191,987	193,256	196,098	203,374	209,794	213,697	224,880	1,269	2,841	7,276	6,421	3,903	11,183	0.7%	1.5%	3.7%	3.2%	1.9%	5.2%	17.1%
8 Bay Pines	252,403	254,034	264,697	279,490	287,964	306,129	337,811	1,631	10,663	14,794	8,474	18,165	31,683	0.6%	4.2%	5.6%	3.0%	6.3%	10.3%	33.8%
9 Nashville	155,876	156,168	161,984	172,706	177,238	180,955	186,779	292	5,815	10,722	4,532	3,718	5,824	0.2%	3.7%	6.6%	2.6%	2.1%	3.2%	19.8%
10 Cincinnati	115,276	114,258	122,250	135,135	139,346	135,999	133,592	-1,018	7,991	12,885	4,211	-3,347	-2,407	-0.9%	7.0%	10.5%	3.1%	-2.4%	-1.8%	15.9%
11 Ann Arbor	138,945	140,674	142,729	149,178	151,045	151,824	156,100	1,729	2,056	6,449	1,866	780	4,276	1.2%	1.5%	4.5%	1.3%	0.5%	2.8%	12.3%
12 Chicago	148,300	145,862	145,818	155,481	156,198	153,294	148,186	-2,438	-43	9,663	717	-2,903	-5,109	-1.6%	0.0%	6.6%	0.5%	-1.9%	-3.3%	-0.1%
15 Kansas City	137,310	136,079	136,954	141,994	145,769	147,699	153,763	-1,231	875	5,040	3,775	1,930	6,063	-0.9%	0.6%	3.7%	2.7%	1.3%	4.1%	12.0%
16 Jackson	304,362	301,751	304,548	319,253	324,333	329,796	343,040	-2,611	2,797	14,704	5,080	5,463	13,244	-0.9%	0.9%	4.8%	1.6%	1.7%	4.0%	12.7%
17 Dallas	148,494	147,530	148,309	157,327	165,364	172,341	182,163	-964	779	9,018	8,037	6,977	9,822	-0.6%	0.5%	6.1%	5.1%	4.2%	5.7%	22.7%
18 Phoenix	141,059	143,950	148,625	157,084	160,202	161,678	169,178	2,891	4,675	8,459	3,118	1,476	7,500	2.0%	3.2%	5.7%	2.0%	0.9%	4.6%	19.9%
19 Denver	92,703	92,843	93,157	97,239	100,520	101,304	105,801	140	313	4,083	3,281	784	4,497	0.2%	0.3%	4.4%	3.4%	0.8%	4.4%	14.1%
20 Portland	144,635	145,403	147,869	155,189	158,886	162,715	167,429	768	2,466	7,320	3,698	3,829	4,714	0.5%	1.7%	5.0%	2.4%	2.4%	2.9%	15.8%
21 San Francisco	137,994	140,718	142,683	152,369	157,224	161,019	169,105	2,724	1,965	9,686	4,855	3,794	8,086	2.0%	1.4%	6.8%	3.2%	2.4%	5.0%	22.5%
22 Long Beach	189,728	193,137	196,263	204,082	208,285	206,527	211,466	3,409	3,126	7,819	4,203	-1,758	4,939	1.8%	1.6%	4.0%	2.1%	-0.8%	2.4%	11.5%
23 Minneapolis	150,538	150,907	150,052	153,775	156,591	159,731	167,766	369	-855	3,724	2,816	3,140	8,035	0.2%	-0.6%	2.5%	1.8%	2.0%	5.0%	11.4%
VHA total	3,237,858	3,251,434	3,330,485	3,518,747	3,606,916	3,647,291	3,779,887	13,576	79,051	188,262	88,169	40,375	132,596	0.4%	2.4%	5.7%	2.5%	1.1%	3.6%	16.7%

Notes: 1. All workload units are adjusted for care provided in more than one network.

2. A policy decision was made to fund Basic Vested patients separately from single outpatient visits, effective for the FY 1999 VERA allocations. Effective for the FY 2000 VERA allocations, a policy decision was made to fund Basic Non Vested patients separately from the Basic Vested patients. Basic vested patients rely on VA for their care and have used inpatient services or have had an appropriate detailed medical evaluation during the past three years.

3. FY 1997 and FY 1998 VERA Basic Workload includes the Single Outpatient Visits and Non-Vested Workload, since those funding groups were created subsequent to the FY 1998 VERA allocation.

4. Numbers may not add due to rounding.

5. The VERA workloads shown above are based on the following fiscal years:

FY 1997 VERA Basic Care workload is the sum of patients seen in FYs 1993-1995.

FY 1998 VERA Basic Care workload is the sum of patients seen in FYs 1994-1996.

FY 1999 VERA Basic Care workload is the sum of Vested plus Single Visit workload for FYs 1995-1997.

FY 2000 VERA Basic Care workload is the sum of Vested plus Non Vested workload for FYs 1996-1998.

FY 2001 VERA Basic Care workload is the sum of Vested plus Non Vested workload for FYs 1997-1999.

FY 2002 VERA Basic Care workload is the sum of Vested plus Non Vested workload for FYs 1998-2000.

FY 2003 VERA Basic Care workload is the sum of workload in Price Groups 1-6 for FYs 1999-2001.

Basic Non-Vested Care Back-up Data FY 1999 to FY 2003

						Difference				% Change			
Network	FY 1999 Single Visit Workload	VERA FY 2000 Non-Vested Workload	VERA FY 2001 Non-Vested Workload	VERA FY 2002 Non-Vested Workload	VERA FY 2003 Non-Vested Workload*	FY 1999 - FY 2000	FY 2000 - FY 2001	FY 2001 - FY 2002	FY 2002 - FY 2003	FY 1999 - FY 2000	FY 2000 - FY 2001	FY 2001 - FY 2002	FY 2002 - FY 2003
1 Boston	17,142	26,518	14,966	12,315	11,216	9,377	(11,552)	(2,651)	(1,099)	54.7%	-43.6%	-17.7%	-8.9%
2 Albany	8,331	14,786	11,213	9,874	9,628	6,456	(3,574)	(1,338)	(246)	77.5%	-24.2%	-11.9%	-2.5%
3 Bronx	17,119	30,683	23,233	21,404	14,487	13,565	(7,451)	(1,828)	(6,918)	79.2%	-24.3%	-7.9%	-32.3%
4 Pittsburgh	27,764	46,484	37,472	31,958	27,020	18,720	(9,012)	(5,515)	(4,938)	67.4%	-19.4%	-14.7%	-15.5%
5 Baltimore	10,567	19,989	11,738	10,724	9,549	9,422	(8,251)	(1,013)	(1,175)	89.2%	-41.3%	-8.6%	-11.0%
6 Durham	18,485	35,651	23,577	19,488	16,079	17,166	(12,074)	(4,089)	(3,409)	92.9%	-33.9%	-17.3%	-17.5%
7 Atlanta	19,745	34,933	19,727	20,028	19,162	15,188	(15,205)	300	(866)	76.9%	-43.5%	1.5%	-4.3%
8 Bay Pines	27,397	40,224	25,402	25,192	23,643	12,827	(14,821)	(210)	(1,549)	46.8%	-36.8%	-0.8%	-6.1%
9 Nashville	18,591	29,566	20,686	16,941	12,920	10,975	(8,880)	(3,745)	(4,021)	59.0%	-30.0%	-18.1%	-23.7%
10 Cincinnati	19,819	35,343	29,977	22,877	13,526	15,524	(5,366)	(7,101)	(9,351)	78.3%	-15.2%	-23.7%	-40.9%
11 Ann Arbor	12,993	26,265	16,135	15,657	13,205	13,272	(10,130)	(478)	(2,452)	102.1%	-38.6%	-3.0%	-15.7%
12 Chicago	15,417	32,562	23,351	21,904	13,315	17,145	(9,211)	(1,447)	(8,588)	111.2%	-28.3%	-6.2%	-39.2%
15 Kansas City	11,528	21,008	14,293	13,062	12,523	9,480	(6,715)	(1,231)	(538)	82.2%	-32.0%	-8.6%	-4.1%
16 Jackson	28,505	53,848	35,383	33,264	26,813	25,343	(18,465)	(2,118)	(6,452)	88.9%	-34.3%	-6.0%	-19.4%
17 Dallas	15,463	24,900	18,602	18,161	16,558	9,437	(6,298)	(442)	(1,603)	61.0%	-25.3%	-2.4%	-8.8%
18 Phoenix	13,575	20,191	12,849	12,377	11,518	6,616	(7,342)	(472)	(859)	48.7%	-36.4%	-3.7%	-6.9%
19 Denver	9,371	16,327	9,283	8,350	7,868	6,956	(7,044)	(933)	(482)	74.2%	-43.1%	-10.1%	-5.8%
20 Portland	13,880	26,213	17,547	17,124	15,581	12,333	(8,666)	(424)	(1,543)	88.9%	-33.1%	-2.4%	-9.0%
21 San Francisco	14,560	28,049	18,914	17,966	16,026	13,489	(9,135)	(948)	(1,940)	92.6%	-32.6%	-5.0%	-10.8%
22 Long Beach	22,324	41,985	27,019	25,205	21,833	19,661	(14,966)	(1,815)	(3,371)	88.1%	-35.6%	-6.7%	-13.4%
23 Minneapolis	11,286	31,170	24,897	22,318	18,534	19,883	(6,273)	(2,579)	(3,784)	176.2%	-20.1%	-10.4%	-17.0%
VHA Totals	353,861	636,696	436,265	396,188	331,004	282,835	(200,431)	(40,077)	(65,184)	79.9%	-31.5%	-9.2%	-16.5%

Figures are pro-rated person counts used in the VERA models.

Note: Numbers may not add due to rounding.

*FY 2003 Non Vested Workload is included in Price Group 1 Non-Reliant Care.

Complex Care: VERA Workload FY 1997 to FY 2003

Network	VERA FY 1997 Special Care	VERA FY 1998 Special Care	VERA FY 1999 Complex Care	VERA FY 2000 Complex Care	VERA FY 2001 Complex Care	VERA FY 2002 Complex Care	VERA FY 2003 Complex Care	Difference FY 1997-FY 1998	Difference FY 1998-FY 1999	Difference FY 1999-FY 2000	Difference FY 2000-FY 2001	Difference FY 2001-FY 2002	Difference FY 2002-FY 2003	% Change FY 1997-FY 1998	% Change FY 1998-FY 1999	% Change FY 1999-FY 2000	% Change FY 2000-FY 2001	% Change FY 2001-FY 2002	% Change FY 2002-FY 2003	% Change FY 1997-FY 2003
1 Boston	7,951	7,616	7,022	6,410	6,209	7,002	6,930	-335	-595	-612	-201	793	-72	-4.2%	-7.8%	-8.7%	-3.1%	12.8%	-1.0%	-12.8%
2 Albany	4,750	4,433	4,396	4,268	4,606	4,607	5,054	-317	-37	-128	338	2	447	-6.7%	-0.8%	-2.9%	7.9%	0.0%	8.8%	6.4%
3 Bronx	10,253	10,309	9,944	8,656	8,220	8,210	8,164	56	-365	-1,288	-436	-10	-46	0.5%	-3.5%	-13.0%	-5.0%	-0.1%	-0.6%	-20.4%
4 Pittsburgh	9,308	8,847	8,416	7,645	8,069	7,682	7,795	-461	-431	-771	424	-388	113	-4.9%	-4.9%	-9.2%	5.5%	-4.8%	1.5%	-16.3%
5 Baltimore	4,090	4,302	4,667	5,040	5,502	5,675	5,579	212	365	373	462	173	-96	5.2%	8.5%	8.0%	9.2%	3.2%	-1.7%	36.4%
6 Durham	6,912	6,270	6,451	6,706	7,244	7,688	7,773	-642	181	255	538	444	85	-9.3%	2.9%	3.9%	8.0%	6.1%	1.1%	12.5%
7 Atlanta	8,881	8,922	8,698	8,085	8,290	9,252	9,392	41	-224	-614	205	963	140	0.5%	-2.5%	-7.1%	2.5%	11.6%	1.5%	5.8%
8 Bay Pines	10,158	10,210	10,718	10,979	11,278	12,598	13,176	52	508	261	299	1,320	578	0.5%	5.0%	2.4%	2.7%	11.7%	4.4%	29.7%
9 Nashville	6,725	6,561	6,384	6,029	6,050	6,462	6,386	-164	-177	-355	21	412	-76	-2.4%	-2.7%	-5.6%	0.3%	6.8%	-1.2%	-5.0%
10 Cincinnati	5,284	5,229	5,635	5,775	6,061	6,618	7,088	-55	406	140	286	557	470	-1.0%	7.8%	2.5%	5.0%	9.2%	6.6%	34.1%
11 Ann Arbor	6,243	5,792	6,082	5,601	6,313	6,315	5,895	-451	290	-481	712	2	-420	-7.2%	5.0%	-7.9%	12.7%	0.0%	-7.1%	-5.6%
12 Chicago	8,407	8,177	8,315	7,931	8,578	8,418	8,390	-230	138	-384	648	-160	-29	-2.7%	1.7%	-4.6%	8.2%	-1.9%	-0.3%	-0.2%
15 Kansas City	6,550	6,018	5,554	4,967	5,246	5,893	5,704	-532	-464	-588	280	646	-189	-8.1%	-7.7%	-10.6%	5.6%	12.3%	-3.3%	-12.9%
16 Jackson	9,298	9,540	9,992	10,307	10,280	10,806	11,180	242	452	315	-28	526	374	2.6%	4.7%	3.2%	-0.3%	5.1%	3.3%	20.2%
17 Dallas	6,679	6,472	6,520	6,591	6,882	7,450	7,462	-207	48	71	291	568	12	-3.1%	0.7%	1.1%	4.4%	8.2%	0.2%	11.7%
18 Phoenix	4,715	4,704	4,881	4,938	5,147	5,240	5,541	-11	177	58	209	93	301	-0.2%	3.8%	1.2%	4.2%	1.8%	5.4%	17.5%
19 Denver	3,241	3,111	2,976	3,049	3,207	3,602	3,821	-130	-136	73	158	395	219	-4.0%	-4.4%	2.4%	5.2%	12.3%	5.7%	17.9%
20 Portland	6,463	6,242	6,482	6,553	6,750	7,112	7,340	-221	241	71	197	362	228	-3.4%	3.9%	1.1%	3.0%	5.4%	3.1%	13.6%
21 San Francisco	6,732	6,423	6,467	6,611	7,316	7,627	7,137	-309	44	144	705	311	-490	-4.6%	0.7%	2.2%	10.7%	4.3%	-6.9%	6.0%
22 Long Beach	7,517	7,500	7,667	7,075	7,775	8,150	8,608	-17	167	-592	699	375	458	-0.2%	2.2%	-7.7%	9.9%	4.8%	5.3%	14.5%
23 Minneapolis	6,731	6,290	6,725	6,392	6,361	6,748	7,325	-441	435	-333	-31	386	577	-6.6%	6.9%	-4.9%	-0.5%	6.1%	7.9%	8.8%
VHA total	146,888	142,969	143,991	139,607	145,385	153,155	155,739	-3,919	1,022	-4,384	5,778	7,770	2,584	-2.7%	0.7%	-3.0%	4.1%	5.3%	1.7%	6.0%

Notes: 1. All the workload units are adjusted for care provided in more than one network.

2. VERA workload presented above is projected based on the past 5 years experience, where-as the data in the following 4 charts labeled "Historical" is the actual workload which occurred in those years.

3. A policy decision was made to change the name of this patient care group from "Special Care" to "Complex Care" effective for the FY 1999 VERA allocations. Additionally, effective for the FY 2000 allocation, several policy decisions affecting workload were approved (for details see page 99 of Appendix 3).

4. The FY 2001, FY 2002 and FY 2003 Complex Care workload forecast continues to include a factor for age, but no longer for veteran population trends.

5. The FY 2002 and FY 2003 Complex Care workload includes approved policy changes for: eliminating the requirement for having twice as many days in a long-term care setting as an acute care setting to qualify for Complex Care; revising Complex Care designations in long-term residential and psychiatric care; and creating a new Complex Care patient class entitled Mental Health Intensive Care Management.

6. FY 2003 figures are the sum of Complex Care workload in Price Groups 7 - 10.

7. Numbers may not add due to rounding.

Complex Care: Back-up data Group 7 - Specialized Care

Network	Historical FY 1997 patients	Historical FY 1998 patients	Historical FY 1999 patients	Historical FY 2000 patients	Historical FY 2001 patients	VERA FY 2003 Complex Care workload units
1 Boston	1,555	1,613	1,694	1,897	1,782	1,799
2 Albany	932	1,291	1,520	1,589	1,721	2,080
3 Bronx	2,596	2,992	3,300	3,272	3,262	3,518
4 Pittsburgh	1,523	1,707	1,980	1,974	2,045	2,215
5 Baltimore	1,081	1,424	1,593	1,698	1,655	1,893
6 Durham	1,444	1,712	1,843	1,975	2,205	2,481
7 Atlanta	2,268	2,545	2,643	2,961	3,041	3,335
8 Bay Pines	2,926	3,411	3,657	3,892	4,167	4,559
9 Nashville	969	1,049	1,314	1,294	1,398	1,490
10 Cincinnati	977	1,156	1,267	1,597	2,042	2,489
11 Ann Arbor	1,301	1,604	1,738	1,802	1,767	1,931
12 Chicago	1,605	1,814	1,927	1,978	1,952	2,069
15 Kansas City	1,012	1,088	1,405	1,623	1,580	1,760
16 Jackson	2,170	2,884	2,999	3,026	3,206	3,481
17 Dallas	1,148	1,424	1,569	1,578	1,540	1,686
18 Phoenix	1,192	1,477	1,577	1,625	1,709	1,857
19 Denver	860	955	1,106	1,129	1,294	1,417
20 Portland	1,302	1,514	1,603	1,613	1,800	1,945
21 San Francisco	1,748	2,152	2,390	2,394	2,369	2,563
22 Long Beach	1,766	1,940	2,370	2,308	2,403	2,611
23 Minneapolis	1,085	1,233	1,380	1,865	1,898	2,246
VHA Total	31,460	36,984	40,873	43,088	44,836	49,425

Notes: 1. All the workload units are adjusted for care provided in more than one network.

2. The 5 columns labeled "Historical FY Patients" display the workload used to compute the projected VERA FY 2003 Complex Care workload. The projection inculdes a factor for age of patients.

3. Numbers may not add due to rounding.

Complex Care: Back-up data Group 8 - Supportive Care

Network	Historical FY 1997 patients	Historical FY 1998 patients	Historical FY 1999 patients	Historical FY 2000 patients	Historical FY 2001 patients	VERA FY 2003 Complex Care workload units
1 Boston	3,106	2,901	2,614	2,620	2,639	2,391
2 Albany	1,803	1,728	1,643	1,675	1,480	1,351
3 Bronx	3,297	2,857	2,540	2,430	2,222	1,749
4 Pittsburgh	3,320	3,153	3,018	2,802	2,601	2,242
5 Baltimore	1,907	1,976	2,002	1,968	1,937	1,957
6 Durham	3,294	3,247	3,129	3,137	2,919	2,740
7 Atlanta	3,978	3,959	3,926	3,698	3,821	3,716
8 Bay Pines	5,047	5,138	5,356	5,493	5,637	5,935
9 Nashville	3,569	3,417	3,390	3,314	3,234	3,080
10 Cincinnati	2,817	2,416	2,379	2,377	2,193	1,936
11 Ann Arbor	2,170	2,093	2,272	2,095	1,965	1,883
12 Chicago	3,793	3,769	3,541	3,580	3,395	3,177
15 Kansas City	2,871	2,672	2,668	2,585	2,412	2,226
16 Jackson	5,443	5,154	4,881	4,687	4,730	4,363
17 Dallas	3,177	2,955	3,008	3,109	3,089	3,068
18 Phoenix	2,450	2,298	2,416	2,422	2,467	2,479
19 Denver	1,162	1,123	1,161	1,216	1,233	1,273
20 Portland	3,222	3,183	3,016	3,204	3,303	3,298
21 San Francisco	2,733	2,698	2,786	2,615	2,455	2,350
22 Long Beach	3,276	3,131	3,261	3,249	3,366	3,422
23 Minneapolis	2,909	2,710	2,581	2,742	2,682	2,575
VHA total	65,343	62,579	61,590	61,020	59,780	57,207

Notes: 1. All the workload units are adjusted for care provided in more than one network.

2. The 5 columns labeled "Historical FY Patients" display the workload used to compute the projected VERA FY 2003 Complex Care workload. The projection inculdes a factor for age of patients.

3. Numbers may not add due to rounding.

Complex Care: Back-up data Group 9 - Chronic Mental Illness

Network	Historical FY 1997 patients	Historical FY 1998 patients	Historical FY 1999 patients	Historical FY 2000 patients	Historical FY 2001 patients	VERA FY 2003 Complex Care workload units
1 Boston	2,299	2,262	2,141	2,029	1,938	1,741
2 Albany	1,295	1,184	1,112	1,080	1,128	1,043
3 Bronx	2,984	2,874	2,543	2,343	2,222	1,837
4 Pittsburgh	2,226	2,137	2,022	1,900	1,811	1,621
5 Baltimore	1,062	1,040	1,012	1,011	1,022	989
6 Durham	1,352	1,324	1,255	1,138	1,140	1,018
7 Atlanta	1,949	1,731	1,564	1,522	1,463	1,237
8 Bay Pines	1,313	1,300	1,171	1,087	1,072	974
9 Nashville	1,149	1,058	1,071	1,007	997	927
10 Cincinnati	1,617	1,604	1,622	1,621	1,631	1,642
11 Ann Arbor	1,852	1,645	1,526	1,475	1,345	1,124
12 Chicago	2,262	2,125	2,093	2,026	1,969	1,835
15 Kansas City	1,362	1,299	1,269	1,257	1,197	1,126
16 Jackson	1,886	1,930	1,848	1,778	1,828	1,785
17 Dallas	1,691	1,752	1,654	1,520	1,499	1,375
18 Phoenix	538	524	523	488	469	432
19 Denver	900	886	792	731	774	696
20 Portland	1,479	1,590	1,532	1,461	1,401	1,343
21 San Francisco	1,181	1,213	1,175	1,172	1,090	1,054
22 Long Beach	1,868	1,768	1,582	1,540	1,532	1,374
23 Minneapolis	1,665	1,545	1,411	1,379	1,299	1,121
VHA total	33,933	32,788	30,917	29,564	28,827	26,296

Notes: 1. All the workload units are adjusted for care provided in more than one network.

2. The 5 columns labeled "Historical FY Patients" display the workload used to compute the projected VERA FY 2003 Complex Care workload. The projection inculdes a factor for age of patients.

3. Numbers may not add due to rounding.

Complex Care: Back-up data Group 10 - Critically Ill

Network	Historical FY 1997 patients	Historical FY 1998 patients	Historical FY 1999 patients	Historical FY 2000 patients	Historical FY 2001 patients	VERA FY 2003 Complex Care workload units
1 Boston	1,160	1,117	1,027	917	1,059	998
2 Albany	918	635	547	476	693	580
3 Bronx	1,498	1,330	1,245	1,114	1,209	1,061
4 Pittsburgh	1,747	1,753	1,657	1,529	1,714	1,716
5 Baltimore	859	749	770	670	759	741
6 Durham	1,472	1,340	1,329	1,309	1,526	1,535
7 Atlanta	1,380	1,221	1,170	1,215	1,165	1,104
8 Bay Pines	1,815	1,736	1,503	1,437	1,777	1,707
9 Nashville	1,473	1,415	1,206	1,075	1,083	889
10 Cincinnati	1,037	920	974	855	1,015	1,021
11 Ann Arbor	1,270	1,112	1,075	1,077	1,049	958
12 Chicago	1,234	982	1,179	1,114	1,265	1,308
15 Kansas City	972	857	650	658	700	592
16 Jackson	1,611	1,445	1,506	1,331	1,584	1,551
17 Dallas	1,178	1,122	1,088	1,054	1,306	1,333
18 Phoenix	903	791	707	658	835	773
19 Denver	592	567	522	451	496	435
20 Portland	903	836	823	683	786	754
21 San Francisco	1,036	1,079	1,038	1,012	1,127	1,170
22 Long Beach	1,091	999	991	982	1,178	1,201
23 Minneapolis	1,399	1,325	1,285	1,101	1,404	1,382
VHA total	25,548	23,331	22,291	20,719	23,731	22,811

Notes: 1. *All the workload units are adjusted for care provided in more than one network.*

2. *The 5 columns labeled "Historical FY Patients" display the workload used to compute the projected VERA FY 2003 Complex Care workload. The projection inculdes a factor for age of patients.*

3. *Numbers may not add due to rounding.*

Total Workload: Back-up Data VERA Workload FY 1997 to FY 2003

Network	VERA FY 1997 Total Workload	VERA FY 1998 Total Workload	VERA FY 1999 Total Workload	VERA FY 2000 Total Workload	VERA FY 2001 Total Workload	VERA FY 2002 Total Workload	VERA FY 2003 Total Workload	Difference FY 1997 FY 1998	Difference FY 1998- FY 1999	Difference FY 1999- FY 2000	Difference FY 2000- FY 2001	Difference FY 2001- FY 2002	Difference FY 2002- FY 2003	% Change FY 1997 - FY 1998	% Change FY 1998 - FY 1999	% Change FY 1999 - FY 2000	% Change FY 2000 - FY 2001	% Change FY 2001 - FY 2002	% Change FY 2002 - FY 2003	% Change FY 1997 - FY 2003
1 Boston	162,836	163,533	166,748	170,650	171,323	169,739	175,109	697	3,215	3,902	673	-1,584	5,369	0.4%	2.0%	2.3%	0.4%	-0.9%	3.2%	7.5%
2 Albany	84,980	85,010	88,247	96,019	101,549	103,590	107,777	30	3,237	7,772	5,529	2,042	4,186	0.0%	3.8%	8.8%	5.8%	2.0%	4.0%	26.8%
3 Bronx	159,989	157,811	158,972	171,513	173,512	168,797	164,079	-2,178	1,161	12,540	2,000	-4,716	-4,718	-1.4%	0.7%	7.9%	1.2%	-2.7%	-2.8%	2.6%
4 Pittsburgh	154,055	159,770	179,634	200,228	213,482	213,665	219,327	5,715	19,865	20,594	13,254	183	5,663	3.7%	12.4%	11.5%	6.6%	0.1%	2.7%	42.4%
5 Baltimore	98,240	98,629	99,711	101,518	102,628	102,370	105,532	389	1,082	1,808	1,109	-258	3,162	0.4%	1.1%	1.8%	1.1%	-0.3%	3.1%	7.4%
6 Durham	171,412	171,890	176,032	183,865	185,511	185,286	192,300	478	4,143	7,833	1,646	-226	7,014	0.3%	2.4%	4.4%	0.9%	-0.1%	3.8%	12.2%
7 Atlanta	200,868	202,179	204,796	211,458	218,084	222,950	234,272	1,311	2,618	6,662	6,626	4,865	11,322	0.7%	1.3%	3.3%	3.1%	2.2%	5.1%	16.6%
8 Bay Pines	262,561	264,244	275,415	290,469	299,242	318,727	350,987	1,683	11,171	15,054	8,773	19,484	32,261	0.6%	4.2%	5.5%	3.0%	6.5%	10.1%	33.7%
9 Nashville	162,601	162,729	168,368	178,736	183,288	187,417	193,165	128	5,639	10,368	4,552	4,130	5,748	0.1%	3.5%	6.2%	2.5%	2.3%	3.1%	18.8%
10 Cincinnati	120,560	119,487	127,884	140,910	145,406	142,616	140,680	-1,073	8,397	13,026	4,496	-2,790	-1,937	-0.9%	7.0%	10.2%	3.2%	-1.9%	-1.4%	16.7%
11 Ann Arbor	145,188	146,465	148,811	154,779	157,358	158,139	161,995	1,277	2,346	5,968	2,579	781	3,856	0.9%	1.6%	4.0%	1.7%	0.5%	2.4%	11.6%
12 Chicago	156,707	154,039	154,133	163,412	164,776	161,713	156,576	-2,668	95	9,279	1,364	-3,064	-5,137	-1.7%	0.1%	6.0%	0.8%	-1.9%	-3.2%	-0.1%
15 Kansas City	143,860	142,097	142,509	146,961	151,016	153,592	159,466	-1,763	412	4,452	4,055	2,576	5,874	-1.2%	0.3%	3.1%	2.8%	1.7%	3.8%	10.8%
16 Jackson	313,660	311,291	314,540	329,560	334,613	340,602	354,220	-2,369	3,249	15,020	5,053	5,989	13,618	-0.8%	1.0%	4.8%	1.5%	1.8%	4.0%	12.9%
17 Dallas	155,173	154,002	154,829	163,918	172,246	179,791	189,625	-1,171	827	9,089	8,328	7,545	9,835	-0.8%	0.5%	5.9%	5.1%	4.4%	5.5%	22.2%
18 Phoenix	145,774	148,653	153,506	162,022	165,349	166,918	174,719	2,879	4,852	8,516	3,327	1,568	7,801	2.0%	3.3%	5.5%	2.1%	0.9%	4.7%	19.9%
19 Denver	95,944	95,955	96,132	100,288	103,727	104,906	109,622	11	177	4,155	3,440	1,179	4,716	0.0%	0.2%	4.3%	3.4%	1.1%	4.5%	14.3%
20 Portland	151,098	151,644	154,351	161,742	165,637	169,827	174,769	546	2,706	7,391	3,895	4,191	4,941	0.4%	1.8%	4.8%	2.4%	2.5%	2.9%	15.7%
21 San Francisco	144,726	147,141	149,150	158,980	164,540	168,646	176,242	2,415	2,009	9,830	5,560	4,106	7,596	1.7%	1.4%	6.6%	3.5%	2.5%	4.5%	21.8%
22 Long Beach	197,245	200,637	203,930	211,157	216,060	214,677	220,074	3,392	3,293	7,228	4,903	-1,383	5,397	1.7%	1.6%	3.5%	2.3%	-0.6%	2.5%	11.6%
23 Minneapolis	157,269	157,196	156,777	160,168	162,953	166,479	175,091	-73	-420	3,391	2,785	3,526	8,612	0.0%	-0.3%	2.2%	1.7%	2.2%	5.2%	11.3%
VHA total	3,384,746	3,394,403	3,474,476	3,658,354	3,752,301	3,800,446	3,935,626	9,657	80,073	183,878	93,947	48,146	135,180	0.3%	2.4%	5.3%	2.6%	1.3%	3.6%	16.3%

Note: 1. All workload units are adjusted for care provided in more than one network.
Note: 2. Numbers may not add due to rounding.

Network Basic and Complex Care Allocations in each of the 10 Price Groups FY 2003

($'s in Millions)

	Basic Care							Complex Care					
Network	1 Non Reliant including Non Vested	2 Basic Medical	3 Mental Health	4 Heart and Lung	5 Oncology	6 Multiple Problem	Sum Basic Care	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	Sum Complex Care	Total
1 Boston	$4	$178	$58	$135	$36	$171	$583	$34	$71	$69	$61	$235	$817
2 Albany	$3	$109	$28	$87	$19	$88	$334	$39	$40	$41	$36	$156	$490
3 Bronx	$5	$170	$45	$116	$46	$151	$532	$66	$52	$72	$65	$255	$787
4 Pittsburgh	$8	$218	$60	$175	$43	$162	$666	$42	$67	$64	$105	$277	$943
5 Baltimore	$4	$104	$25	$77	$24	$91	$325	$35	$58	$39	$45	$178	$503
6 Durham	$5	$200	$52	$154	$41	$161	$613	$47	$82	$40	$94	$262	$876
7 Atlanta	$7	$255	$64	$180	$48	$173	$726	$63	$111	$49	$68	$290	$1,016
8 Bay Pines	$8	$388	$90	$267	$86	$324	$1,163	$85	$177	$38	$104	$405	$1,568
9 Nashville	$5	$206	$50	$152	$44	$166	$623	$28	$92	$37	$54	$211	$834
10 Cincinnati	$4	$140	$50	$109	$29	$104	$437	$47	$58	$65	$62	$232	$668
11 Ann Arbor	$5	$163	$49	$132	$32	$143	$523	$36	$56	$44	$59	$195	$718
12 Chicago	$5	$158	$39	$113	$34	$153	$502	$39	$95	$72	$80	$286	$788
15 Kansas City	$4	$168	$43	$129	$38	$132	$515	$33	$66	$44	$36	$180	$695
16 Jackson	$9	$390	$96	$277	$87	$280	$1,138	$65	$130	$70	$95	$360	$1,498
17 Dallas	$7	$214	$43	$121	$36	$157	$577	$32	$91	$54	$82	$259	$836
18 Phoenix	$4	$200	$41	$134	$39	$141	$560	$35	$74	$17	$47	$173	$733
19 Denver	$3	$122	$29	$74	$24	$91	$344	$27	$38	$27	$27	$119	$463
20 Portland	$6	$183	$57	$106	$39	$143	$535	$36	$98	$53	$46	$234	$768
21 San Francisco	$6	$184	$50	$118	$54	$141	$552	$48	$70	$42	$72	$231	$784
22 Long Beach	$8	$237	$64	$128	$57	$198	$692	$49	$102	$54	$73	$279	$971
23 Minneapolis	$6	$184	$42	$126	$35	$146	$539	$42	$77	$44	$85	$248	$787
VHA Totals	$117	$4,169	$1,076	$2,910	$890	$3,317	$12,479	$927	$1,704	$1,037	$1,395	$5,063	$17,542
National Average Price per Patient in $s:	$263	$2,413	$3,562	$3,722	$8,337	$7,935		$18,751	$29,780	$39,448	$61,177		

Note: The numbers may not add due to rounding.

Formula for computing Basic and Complex Care Allocations in each of the 10 Price Groups is: Workload in price group times national average price per patient for price group.

Network Basic and Complex Care Patients Receiving High Cost Payments in each of the 10 Price Groups FY 2003

	Basic Care							Complex Care					
Network	1 Non Reliant including Non Vested	2 Basic Medical	3 Mental Health	4 Heart and Lung	5 Oncology	6 Multiple Problem	Sum Basic Care	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	Sum Complex Care	Total
1 Boston	1	32	7	90	32	205	366	71	322	454	559	1,406	1,773
2 Albany	0	10	4	44	16	95	169	70	158	118	313	658	827
3 Bronx	1	36	5	82	79	291	495	196	467	605	688	1,955	2,450
4 Pittsburgh	0	68	8	67	30	117	290	88	342	296	761	1,487	1,777
5 Baltimore	1	21	2	60	19	115	218	89	300	277	342	1,007	1,226
6 Durham	7	17	2	40	19	94	179	73	384	197	638	1,292	1,471
7 Atlanta	1	44	2	100	34	170	351	99	484	212	613	1,408	1,759
8 Bay Pines	1	27	3	57	29	154	271	94	601	109	716	1,518	1,789
9 Nashville	1	17	0	75	29	177	300	44	243	115	395	796	1,096
10 Cincinnati	1	25	12	39	20	111	208	91	237	218	370	916	1,124
11 Ann Arbor	0	25	3	69	20	146	262	69	268	297	459	1,093	1,356
12 Chicago	0	54	3	86	41	209	393	100	397	367	554	1,418	1,811
15 Kansas City	1	20	3	37	23	109	194	51	179	112	237	578	772
16 Jackson	2	69	13	139	58	267	549	120	451	187	745	1,502	2,051
17 Dallas	0	21	3	82	26	109	241	62	244	191	514	1,011	1,253
18 Phoenix	0	17	0	55	24	99	195	64	167	40	348	619	814
19 Denver	2	18	4	32	23	90	169	43	119	121	234	518	687
20 Portland	0	31	2	68	31	172	304	108	271	97	380	856	1,160
21 San Francisco	0	43	5	97	36	168	349	154	344	203	573	1,273	1,622
22 Long Beach	0	51	3	119	68	204	446	118	489	262	602	1,471	1,916
23 Minneapolis	1	9	3	57	15	155	240	93	173	173	517	956	1,196
VHA Totals	20	655	87	1,495	671	3,259	6,187	1,896	6,637	4,651	10,557	23,741	29,928
Percentage of Patients receiving High Cost Payments	0.00%	0.04%	0.03%	0.19%	0.63%	0.78%	0.16%	3.84%	11.60%	17.69%	46.28%	15.24%	0.76%

Note: The numbers may not add due to rounding.

Network Basic and Complex Care Percent of Patients Receiving High Cost Payments in each of the 10 Price Groups FY 2003

	Basic Care							Complex Care					
Network	1 Non Reliant including Non Vested	2 Basic Medical	3 Mental Health	4 Heart and Lung	5 Oncology	6 Multiple Problem	Sum Basic Care	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	Sum Complex Care	Total
1 Boston	0.0%	0.0%	0.0%	0.2%	0.7%	1.0%	0.2%	4.0%	13.5%	26.1%	56.0%	20.3%	1.0%
2 Albany	0.0%	0.0%	0.1%	0.2%	0.7%	0.9%	0.2%	3.4%	11.7%	11.3%	53.9%	13.0%	0.8%
3 Bronx	0.0%	0.1%	0.0%	0.3%	1.4%	1.5%	0.3%	5.6%	26.7%	32.9%	64.8%	23.9%	1.5%
4 Pittsburgh	0.0%	0.1%	0.0%	0.1%	0.6%	0.6%	0.1%	4.0%	15.2%	18.3%	44.3%	19.1%	0.8%
5 Baltimore	0.0%	0.0%	0.0%	0.3%	0.6%	1.0%	0.2%	4.7%	15.3%	28.0%	46.1%	18.1%	1.2%
6 Durham	0.0%	0.0%	0.0%	0.1%	0.4%	0.5%	0.1%	2.9%	14.0%	19.3%	41.6%	16.6%	0.8%
7 Atlanta	0.0%	0.0%	0.0%	0.2%	0.6%	0.8%	0.2%	3.0%	13.0%	17.2%	55.5%	15.0%	0.8%
8 Bay Pines	0.0%	0.0%	0.0%	0.1%	0.3%	0.4%	0.1%	2.1%	10.1%	11.1%	41.9%	11.5%	0.5%
9 Nashville	0.0%	0.0%	0.0%	0.2%	0.6%	0.8%	0.2%	2.9%	7.9%	12.4%	44.4%	12.5%	0.6%
10 Cincinnati	0.0%	0.0%	0.1%	0.1%	0.6%	0.8%	0.2%	3.7%	12.2%	13.3%	36.3%	12.9%	0.8%
11 Ann Arbor	0.0%	0.0%	0.0%	0.2%	0.5%	0.8%	0.2%	3.6%	14.2%	26.5%	48.0%	18.5%	0.8%
12 Chicago	0.0%	0.1%	0.0%	0.3%	1.0%	1.1%	0.3%	4.8%	12.5%	20.0%	42.3%	16.9%	1.2%
15 Kansas City	0.0%	0.0%	0.0%	0.1%	0.5%	0.7%	0.1%	2.9%	8.0%	9.9%	40.0%	10.1%	0.5%
16 Jackson	0.0%	0.0%	0.0%	0.2%	0.6%	0.8%	0.2%	3.4%	10.3%	10.5%	48.0%	13.4%	0.6%
17 Dallas	0.0%	0.0%	0.0%	0.3%	0.6%	0.6%	0.1%	3.7%	8.0%	13.9%	38.6%	13.6%	0.7%
18 Phoenix	0.0%	0.0%	0.0%	0.2%	0.5%	0.6%	0.1%	3.4%	6.7%	9.3%	45.0%	11.2%	0.5%
19 Denver	0.0%	0.0%	0.0%	0.2%	0.8%	0.8%	0.2%	3.0%	9.3%	17.4%	53.9%	13.5%	0.6%
20 Portland	0.0%	0.0%	0.0%	0.2%	0.7%	1.0%	0.2%	5.5%	8.2%	7.2%	50.4%	11.7%	0.7%
21 San Francisco	0.0%	0.1%	0.0%	0.3%	0.6%	0.9%	0.2%	6.0%	14.6%	19.2%	48.9%	17.8%	0.9%
22 Long Beach	0.0%	0.1%	0.0%	0.3%	1.0%	0.8%	0.2%	4.5%	14.3%	19.0%	50.1%	17.1%	0.9%
23 Minneapolis	0.0%	0.0%	0.0%	0.2%	0.4%	0.8%	0.1%	4.1%	6.7%	15.5%	37.4%	13.0%	0.7%
VHA Totals	0.0%	0.0%	0.0%	0.2%	0.6%	0.8%	0.2%	3.8%	11.6%	17.7%	46.3%	15.2%	0.8%

Note: The numbers may not add due to rounding.

Network Basic and Complex Care High Cost Patient Allocations in each of the 10 Price Groups FY 2003

($s in millions)

	Basic Care							Complex Care					
Network	1 Non Reliant including Non Vested	2 Basic Medical	3 Mental Health	4 Heart and Lung	5 Oncology	6 Multiple Problem	Sum Basic Care	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	Sum Complex Care	Total
1 Boston	$0.1	$1.7	$0.5	$3.0	$1.3	$7	$14	$5	$14	$19	$30	$68	$82
2 Albany	$0.0	$0.8	$0.1	$1.6	$0.3	$3	$6	$8	$5	$5	$14	$32	$38
3 Bronx	$0.0	$2.7	$0.1	$3.8	$7.7	$14	$29	$8	$32	$37	$46	$123	$152
4 Pittsburgh	$0.0	$3.3	$0.3	$2.7	$1.6	$4	$12	$4	$10	$12	$32	$59	$71
5 Baltimore	$0.0	$0.5	$0.1	$1.8	$0.7	$4	$7	$3	$13	$11	$18	$44	$51
6 Durham	$0.2	$2.5	$0.1	$1.6	$0.5	$3	$8	$3	$19	$7	$31	$60	$67
7 Atlanta	$0.3	$1.4	$0.2	$9.1	$1.6	$6	$19	$4	$21	$8	$28	$60	$79
8 Bay Pines	$0.0	$2.3	$0.4	$3.2	$1.1	$4	$11	$4	$27	$4	$34	$69	$80
9 Nashville	$0.0	$0.6	$0.0	$2.9	$1.1	$5	$10	$1	$8	$3	$19	$30	$40
10 Cincinnati	$0.0	$2.2	$0.4	$1.7	$1.0	$4	$10	$4	$9	$8	$21	$42	$51
11 Ann Arbor	$0.0	$1.2	$0.0	$2.1	$1.6	$5	$10	$2	$14	$14	$25	$56	$66
12 Chicago	$0.0	$1.6	$0.1	$2.7	$1.8	$8	$14	$5	$20	$18	$31	$75	$89
15 Kansas City	$0.0	$0.7	$0.1	$1.3	$0.9	$4	$7	$2	$7	$3	$12	$24	$32
16 Jackson	$0.0	$3.7	$1.9	$5.4	$2.2	$9	$22	$5	$18	$6	$36	$66	$88
17 Dallas	$0.0	$1.6	$0.0	$3.3	$1.3	$4	$11	$2	$11	$9	$21	$44	$54
18 Phoenix	$0.0	$0.9	$0.0	$1.5	$1.2	$2	$6	$2	$7	$1	$17	$28	$33
19 Denver	$0.2	$0.9	$0.1	$1.0	$0.7	$3	$6	$1	$5	$5	$13	$24	$30
20 Portland	$0.0	$1.4	$0.1	$2.7	$1.0	$8	$13	$4	$13	$3	$25	$45	$58
21 San Francisco	$0.0	$1.3	$0.1	$5.0	$1.2	$6	$13	$6	$23	$11	$38	$78	$92
22 Long Beach	$0.0	$3.5	$0.1	$3.9	$3.4	$9	$20	$4	$26	$10	$37	$77	$97
23 Minneapolis	$0.1	$0.2	$0.4	$1.4	$0.3	$4	$7	$3	$5	$6	$24	$39	$45
VHA Totals	$0.9	$35.3	$5.0	$61.6	$32.2	$118	$253	$79	$309	$203	$551	$1,143	$1,395
Average High Cost Payment in $s:	$46,175	$53,892	$57,336	$41,186	$47,928	$36,078	$40,815	$41,774	$46,619	$43,545	$52,238	$48,128	$46,616

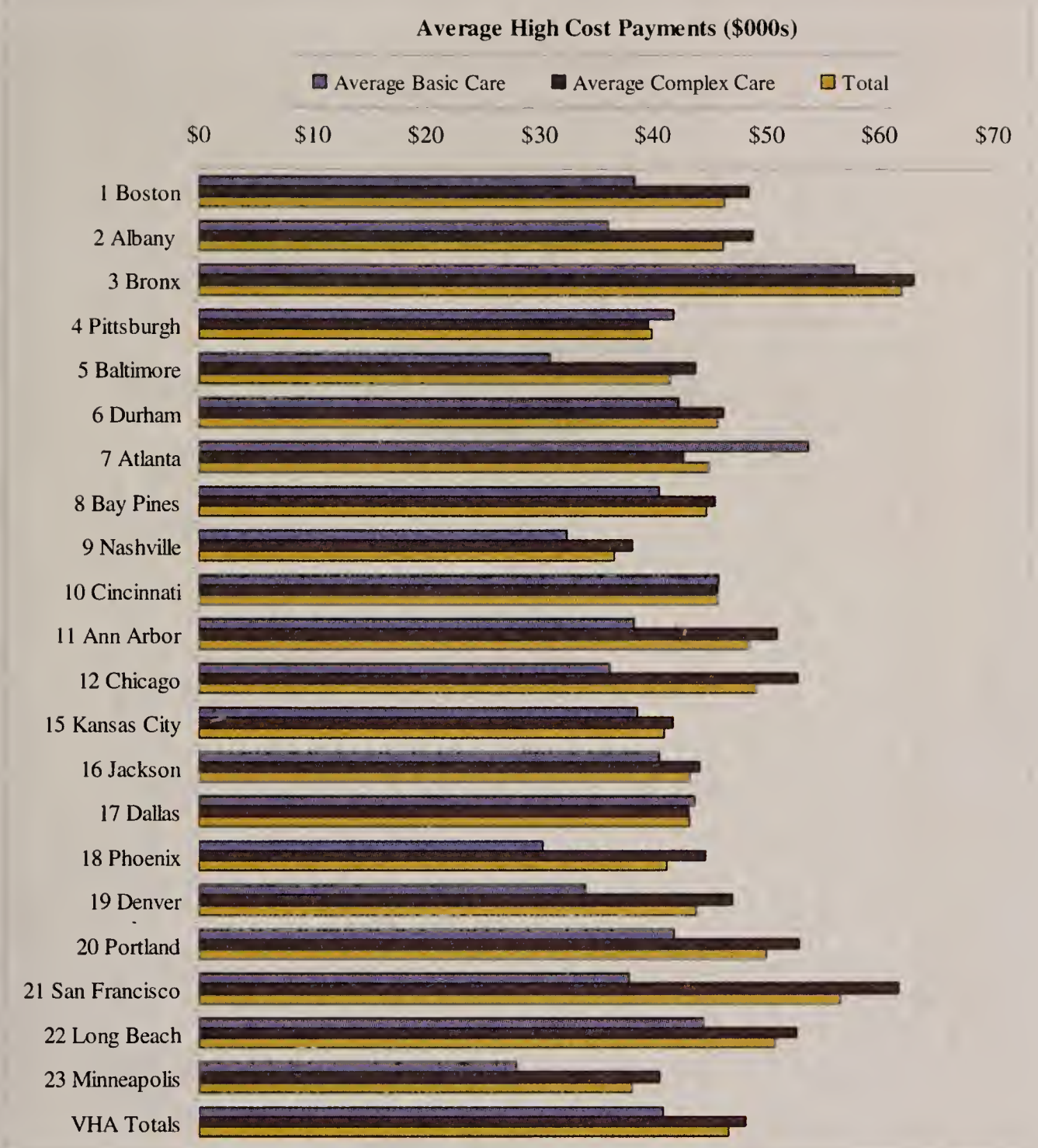
Note: Numbers may not add due to rounding.

Network Basic and Complex Care Average High Cost Patient Allocations in each of the 10 Price Groups FY 2003

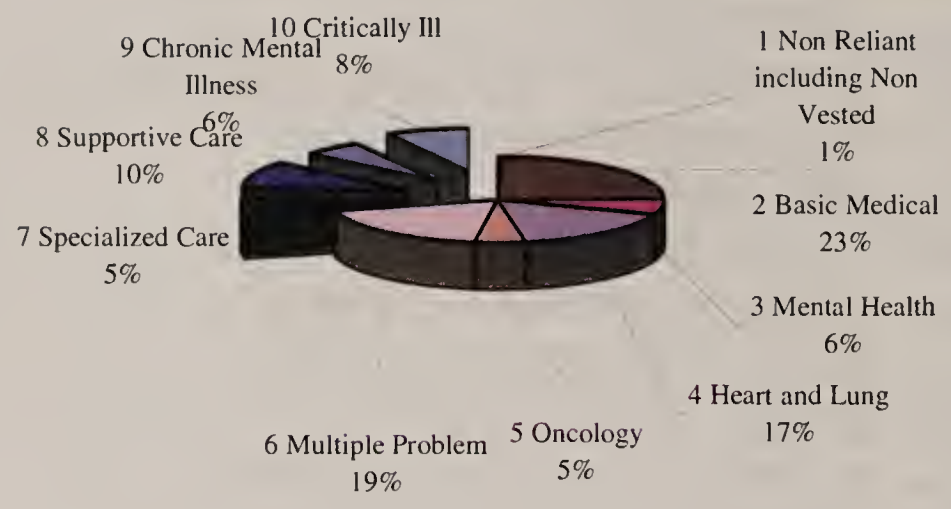
($s in thousands)

	Basic Care							Complex Care					
Network	1 Non Reliant including Non Vested	2 Basic Medical	3 Mental Health	4 Heart and Lung	5 Oncology	6 Multiple Problem	Average Basic Care	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	Average Complex Care	Total
1 Boston	$85	$55	$76	$34	$41	$36	$38	$70	$44	$42	$53	$48	$46
2 Albany		$77	$27	$37	$19	$35	$36	$107	$32	$44	$46	$49	$46
3 Bronx	$30	$75	$20	$46	$97	$49	$58	$40	$70	$61	$67	$63	$62
4 Pittsburgh		$48	$35	$40	$54	$36	$42	$42	$30	$42	$42	$40	$40
5 Baltimore	$16	$25	$57	$30	$39	$31	$31	$31	$44	$38	$51	$44	$41
6 Durham	$30	$148	$34	$40	$28	$28	$42	$35	$50	$34	$49	$46	$46
7 Atlanta	$251	$32	$75	$91	$47	$37	$54	$36	$42	$37	$46	$43	$45
8 Bay Pines	$21	$86	$122	$57	$38	$26	$40	$38	$45	$33	$48	$45	$45
9 Nashville	$21	$37		$38	$37	$29	$32	$26	$32	$26	$47	$38	$37
10 Cincinnati	$32	$90	$34	$42	$48	$38	$46	$40	$39	$38	$56	$46	$46
11 Ann Arbor		$50	$11	$30	$81	$35	$38	$35	$54	$48	$54	$51	$48
12 Chicago		$30	$22	$32	$44	$38	$36	$50	$51	$50	$56	$53	$49
15 Kansas City	$12	$35	$33	$35	$38	$41	$39	$39	$41	$30	$49	$42	$41
16 Jackson	$9	$54	$149	$39	$37	$34	$41	$46	$40	$34	$49	$44	$43
17 Dallas		$75	$16	$40	$48	$40	$44	$35	$45	$49	$41	$43	$43
18 Phoenix		$53	$40	$27	$50	$23	$30	$29	$44	$26	$50	$45	$41
19 Denver	$79	$53	$16	$32	$29	$32	$34	$30	$44	$38	$56	$47	$44
20 Portland		$46	$37	$40	$31	$44	$42	$39	$48	$30	$66	$53	$50
21 San Francisco		$31	$18	$52	$33	$33	$38	$42	$67	$56	$66	$62	$56
22 Long Beach		$68	$33	$33	$49	$44	$44	$36	$53	$39	$61	$53	$51
23 Minneapolis	$70	$23	$121	$24	$18	$28	$28	$32	$31	$37	$47	$41	$38
VHA Totals	$46	$54	$57	$41	$48	$36	$41	$42	$47	$44	$52	$48	$47

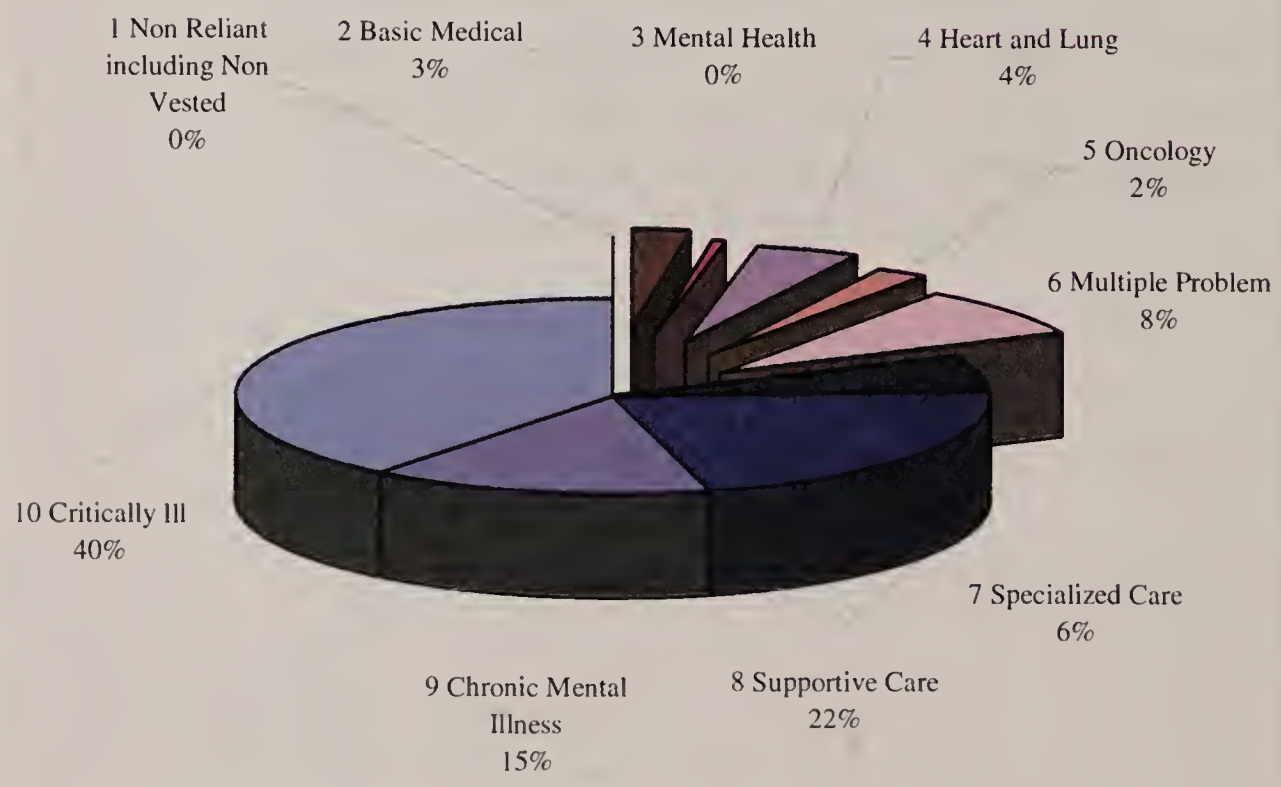
Note: The numbers may not add due to rounding.


Average High Cost Payments ($000s)
Average Basic Care
Average Complex Care
Total
$0
$10
$20
$30
$40
$50
$60
$70
1 Boston
2 Albany
3 Bronx
4 Pittsburgh
5 Baltimore
6 Durham
7 Atlanta
8 Bay Pines
9 Nashville
10 Cincinnati
11 Ann Arbor
12 Chicago
15 Kansas City
16 Jackson
17 Dallas
18 Phoenix
19 Denver
20 Portland
21 San Francisco
22 Long Beach
23 Minneapolis
VHA Totals

Workload Based Funding
Distribution of $17.542 Billion



High Cost Patient Funding
Distribution of $1.395 Billion



Geographic Price Adjustment: Back-up data
($ in thousands)

Network	VISN Salary Rate (V_{sr}) computed by multiplying the national FTE by the VISN average salary using 4 recent pay periods, NORMAL pay only	National Salary Rate (N_{sr}) computed by multiplying the national FTE by the national average salary using 4 recent pay periods, NORMAL pay only	Labor Index (Li)	Volume Basic and Complex Care unweighted workload (Vbc)	Volume Basic and Complex Care weighted workload (Vbcw)	National price for labor (N1)	Labor dollars budgeted based on workload (Lb)	Personal Service Dollars Indexed (PSi)	Scaling factor	Personal Services Dollars Indexed and Scaled (PSis)	Labor Adjustment (LA)
1 Boston	$1,819,833	$1,764,424	1.03140	175,109	239,123	$2,614	625,168	$644,800	1.002	$645,829	$20,663
2 Albany	$1,722,423	$1,763,796	0.97654	107,777	154,457	$2,614	403,815	$394,343	1.002	$394,972	($8,841)
3 Bronx	$1,925,755	$1,764,599	1.09133	164,079	239,489	$2,614	626,125	$683,307	1.002	$684,397	$58,275
4 Pittsburgh	$1,744,761	$1,763,977	0.98911	219,327	291,324	$2,614	761,644	$753,347	1.002	$754,550	($7,092)
5 Baltimore	$1,815,978	$1,764,690	1.02906	105,532	157,063	$2,614	410,630	$422,564	1.002	$423,238	$12,610
6 Durham	$1,716,898	$1,764,424	0.97306	192,300	264,098	$2,614	690,463	$671,865	1.002	$672,937	($17,524)
7 Atlanta	$1,722,746	$1,764,515	0.97633	234,272	321,020	$2,614	839,281	$819,414	1.002	$820,722	($18,557)
8 Bay Pines	$1,668,309	$1,764,599	0.94543	350,987	472,687	$2,614	1,235,804	$1,168,369	1.002	$1,170,234	($65,567)
9 Nashville	$1,703,043	$1,764,599	0.96512	193,165	252,148	$2,614	659,220	$636,224	1.002	$637,239	($21,979)
10 Cincinnati	$1,753,574	$1,764,599	0.99375	140,680	206,147	$2,614	538,954	$535,587	1.002	$536,442	($2,511)
11 Ann Arbor	$1,759,364	$1,764,515	0.99708	161,995	216,446	$2,614	565,880	$564,228	1.002	$565,129	($750)
12 Chicago	$1,813,495	$1,764,599	1.02771	156,576	234,069	$2,614	611,955	$628,912	1.002	$629,916	$17,963
15 Kansas City	$1,706,746	$1,764,599	0.96721	159,466	212,149	$2,614	554,646	$536,462	1.002	$537,318	($17,326)
16 Jackson	$1,738,764	$1,763,977	0.98571	354,220	457,485	$2,614	1,196,059	$1,178,964	1.002	$1,180,846	($15,210)
17 Dallas	$1,708,021	$1,763,977	0.96828	189,625	258,551	$2,614	675,960	$654,518	1.002	$655,562	($20,396)
18 Phoenix	$1,699,704	$1,763,573	0.96378	174,719	225,900	$2,614	590,598	$569,209	1.002	$570,118	($20,479)
19 Denver	$1,738,822	$1,760,398	0.98774	109,622	144,915	$2,614	378,868	$374,224	1.002	$374,822	($4,045)
20 Portland	$1,771,035	$1,764,243	1.00385	174,769	242,561	$2,614	634,157	$636,599	1.002	$637,615	$3,459
21 San Francisco	$1,980,023	$1,763,796	1.12259	176,242	242,165	$2,614	633,120	$710,736	1.002	$711,870	$78,752
22 Long Beach	$1,840,105	$1,764,424	1.04289	220,074	299,583	$2,614	783,237	$816,832	1.002	$818,136	$34,901
23 Minneapolis	$1,731,161	$1,761,297	0.98842	175,091	242,747	$2,614	634,644	$627,293	1.002	$628,295	($6,347)
VHA total	$1,764,690	$1,764,690	1.00000	3,935,626	5,374,125	2,614	14,050,228	$14,050,228	1.002	$14,072,653	$0

Notes: *1. Numbers may not add due to rounding.*
2. For the FY 2000 allocations, a policy decision was made to use a national staffing pattern rather than actual VISN staffing patterns for the Geographic Price Index.
3. For the FY 2001 allocations, a policy decision was made to change the workload factor for computing the labor index to weight Complex Care workload consistent with recent costs.
4. For the FY 2002 allocation, a policy decision was made to change the geographic price adjustment to account for local cost of living factors associated with procuring contracted labor and non-labor contracted goods such as energy related products, utilities and provisions. This decision remains unchanged for FY 2003.
5. The labor index was applied separately to Networks 13 and 14 and the result summed for Network 23.

Formulas for Geographic Price Adjustment (Labor Index): LA = PSis-Lb

Li= $(V_{sr}) / (N_{sr})$	**Labor Index = VISN Salary Rate (Vsr) (national FTE * VISN average salary) / National Salary Rate (Nsr) (national FTE * national average salary)**
	(Weighting factor= 9.9 = National Cost Complex Care / National Cost Basic Vested Care)
Vbcw=	**Volume Basic Complex Weighted Workload= Volume Complex * Weighting factor + Volume Basic (Vested plus Non-Vested)**
Nl= L_b/V_{bcw}	**National price for labor VHA labor dollars budgeted based on workload / total volume of Basic and Complex Care workload weighted**
L_b= V_{bcw} * Nl	**Labor dollars based on workload = Volume of Basic and Complex weighted * National price for labor**
PSi = Lb * Li	**Personal services dollars indexed = Labor dollars budgeted based on weighted workload * Labor Index**
PSis= PSi * 1.002	**Personal service dollars indexed and scaled = Personal services dollars indexed * 1.002 scaling factor**
LA = PSis -Lb	**Labor Adjustment = Personal service dollars indexed and scaled - labor dollars based on workload**

Research Support Budget: Back-up data
($ in millions)

	FY 2001 Total Dollars of Research Reported				FY 2001 Total Dollars Research Reported and Weighted					
Network	Administered by VA (VA)	Peer Reviewed Not Administered by VA (PR)	Not Peer Reviewed (NPR)	FY 2001 Funded Research Reported for FY 2003 VERA(V_r)	Administered by VA (weighted at 100%) (VA_W)	Peer Reviewed Not Administered by VA (weighted at 75%) (PR_W)	Not Peer Reviewed (weighted at 25%) (NPR_W)	FY 2001 Weighted Research Activity for FY 2003 VERA (V_{rw})	National Price for Research Support (N_{rs})	**Budget for Research Support (B_{rs}) ($000s)**
1 Boston	$40	$27	$1	$69	$40	$21	$0.37	$61	$0.54	$33,020
2 Albany	$5	$4	$0	$9	$5	$3	$0.07	$8	$0.54	$4,416
3 Bronx	$11	$14	$1	$26	$11	$10	$0.27	$21	$0.54	$11,574
4 Pittsburgh	$13	$19	$1	$34	$13	$15	$0.24	$28	$0.54	$15,286
5 Baltimore	$22	$16	$5	$43	$22	$12	$1.25	$35	$0.54	$19,120
6 Durham	$20	$4	$1	$26	$20	$3	$0.24	$24	$0.54	$12,862
7 Atlanta	$23	$14	$3	$39	$23	$10	$0.63	$34	$0.54	$18,524
8 Bay Pines	$16	$8	$9	$33	$16	$6	$2.19	$24	$0.54	$13,082
9 Nashville	$16	$12	$3	$31	$16	$9	$0.67	$26	$0.54	$14,025
10 Cincinnati	$12	$16	$2	$30	$12	$12	$0.42	$25	$0.54	$13,314
11 Ann Arbor	$14	$21	$5	$40	$14	$16	$1.16	$32	$0.54	$17,096
12 Chicago	$24	$20	$5	$48	$24	$15	$1.23	$40	$0.54	$21,395
15 Kansas City	$4	$5	$1	$10	$4	$4	$0.25	$8	$0.54	$4,543
16 Jackson	$21	$19	$6	$47	$21	$14	$1.56	$37	$0.54	$20,188
17 Dallas	$13	$20	$3	$37	$13	$15	$0.75	$29	$0.54	$15,791
18 Phoenix	$16	$2	$1	$18	$16	$2	$0.22	$17	$0.54	$9,371
19 Denver	$10	$5	$1	$16	$10	$4	$0.26	$14	$0.54	$7,721
20 Portland	$24	$23	$3	$50	$24	$17	$0.66	$42	$0.54	$22,969
21 San Francisc	$64	$37	$9	$109	$64	$28	$2.17	$94	$0.54	$50,710
22 Long Beach	$56	$47	$4	$108	$56	$35	$1.09	$93	$0.54	$50,170
23 Minneapolis	$20	$34	$3	$58	$20	$25	$0.83	$47	$0.54	$25,198
VHA total	$447	$369	$66	$882	$447	$277	$16.52	$740	$0.54	$400,375

Note: Numbers may not add due to rounding.

Formulas for Research Support: $B_{rs}=V_{rw}*N_{rs}$	
$B_{rs}=Vrw*Nrs$	Budget for research support = research reported and weighted* National price for research support
$VA_W=VA$	Research which is administered by the VA is weighted at 100%
$PR_W=PR*.75$	Research which is peer reviewed, but not VA administered is weighted at 75%
$NPR_W=NPR*.25$	Research which is not peer reviewed and not administered by VA is weighted at 25%
$V_{rw}=VA_w+PR_w+NPR_w$	Research activity weighted = Sum of weighted research activity
$N_{rs}=B_{rs}/V_{rw}$	National price for research support = Budget for Research reported divided by research reported and weighted

Education Support: Back-up data
($ in thousands)

Network	Volume Resident FTE for FY 1997 VERA	Volume Resident FTE for FY 1998 VERA	Volume Resident FTE for FY 1999 VERA	Volume Resident FTE for FY 2000 VERA	Volume Resident FTE for FY 2001 VERA	Volume Resident FTE for FY 2002 VERA	Volume Resident FTE (V_e) for FY 2003 VERA	National Price for Education Support (N_{es})	Budget for Education Support (B_{es})
1 Boston	542	534	525	515	506	501	514	$40,469	$20,802
2 Albany	276	264	249	246	243	243	240	$40,469	$9,704
3 Bronx	611	609	584	588	601	603	602	$40,469	$24,350
4 Pittsburgh	338	304	304	321	320	329	322	$40,469	$13,015
5 Baltimore	239	244	241	246	239	246	248	$40,469	$10,016
6 Durham	367	366	364	349	353	348	369	$40,469	$14,941
7 Atlanta	455	455	441	438	436	427	442	$40,469	$17,882
8 Bay Pines	563	554	546	547	548	555	564	$40,469	$22,825
9 Nashville	547	555	549	528	531	529	545	$40,469	$22,048
10 Cincinnati	265	261	251	254	255	256	260	$40,469	$10,538
11 Ann Arbor	315	324	323	319	317	314	317	$40,469	$12,825
12 Chicago	662	673	658	657	656	657	652	$40,469	$26,386
15 Kansas City	346	346	343	339	336	339	331	$40,469	$13,395
16 Jackson	713	695	675	682	680	674	680	$40,469	$27,533
17 Dallas	336	337	333	333	331	333	338	$40,469	$13,678
18 Phoenix	300	296	310	305	305	306	312	$40,469	$12,614
19 Denver	229	236	228	234	230	230	235	$40,469	$9,490
20 Portland	269	262	269	269	276	273	278	$40,469	$11,266
21 San Francisco	384	382	387	380	385	383	405	$40,469	$16,371
22 Long Beach	730	745	736	719	728	730	736	$40,469	$29,777
23 Minneapolis	408	409	407	392	387	393	399	$40,469	$16,141
VHA total	8,891	8,848	8721	8,659	8,662	8,669	8,787	$40,469	$355,599

Note: Numbers may not add due to rounding.

Formula for Education support allocation: $B_{es}=V_e*N_{es}$

B_{es} = Network budget for education support = Volume of Residents * National price for education support

$N_{es} = B_{es} / V_e$ = National price for education support = Budget for education support divided by volume of residents

Equipment Distribution: Back-up data
($ in thousands)

Network	FY 1997 VERA Equipment Allocation	FY 1998 VERA Equipment Allocation	FY 1999 VERA Equipment Allocation	FY 2000 VERA Equipment Allocation	FY 2001 VERA Equipment Allocation	FY 2002 VERA Equipment Allocation	Volume Basic and Complex (V_{bc})	Price (N_{eq})	Total Equipment Budget (B_{eq})
1 Boston	$18,193	$23,566	$23,664	$25,970	$27,625	$19,037	175,109	$147	$25,704
2 Albany	$9,962	$12,937	$12,813	$14,613	$16,374	$11,618	107,777	$147	$15,821
3 Bronx	$18,538	$24,367	$23,369	$26,102	$27,978	$18,931	164,079	$147	$24,085
4 Pittsburgh	$17,685	$23,460	$24,836	$30,472	$34,423	$23,964	219,327	$147	$32,195
5 Baltimore	$9,956	$13,207	$13,931	$15,450	$16,548	$11,481	105,532	$147	$15,491
6 Durham	$17,522	$22,084	$24,130	$27,982	$29,913	$20,781	192,300	$147	$28,228
7 Atlanta	$19,442	$24,984	$27,032	$32,181	$35,165	$25,005	234,272	$147	$34,389
8 Bay Pines	$24,076	$31,079	$35,619	$44,205	$48,252	$35,747	350,987	$147	$51,521
9 Nashville	$18,661	$24,094	$24,481	$27,201	$29,555	$21,020	193,165	$147	$28,355
10 Cincinnati	$12,612	$16,583	$17,540	$21,444	$23,446	$15,995	140,680	$147	$20,650
11 Ann Arbor	$14,434	$18,309	$20,097	$23,555	$25,373	$17,736	161,995	$147	$23,779
12 Chicago	$18,421	$24,105	$22,973	$24,869	$26,570	$18,137	156,576	$147	$22,984
15 Kansas City	$15,406	$19,360	$19,731	$22,365	$24,351	$17,226	159,466	$147	$23,408
16 Jackson	$31,533	$40,664	$42,820	$50,154	$53,955	$38,200	354,220	$147	$51,996
17 Dallas	$15,138	$19,779	$20,846	$24,946	$27,774	$20,165	189,625	$147	$27,835
18 Phoenix	$14,244	$18,518	$20,251	$24,657	$26,662	$18,721	174,719	$147	$25,647
19 Denver	$9,804	$12,766	$13,126	$15,262	$16,726	$11,766	109,622	$147	$16,091
20 Portland	$15,114	$20,068	$21,113	$24,615	$26,708	$19,047	174,769	$147	$25,654
21 San Francisco	$14,122	$19,161	$20,206	$24,194	$26,532	$18,915	176,242	$147	$25,870
22 Long Beach	$18,381	$24,531	$26,826	$32,135	$34,839	$24,077	220,074	$147	$32,305
23 Minneapolis	$19,421	$24,746	$23,118	$24,375	$26,276	$18,671	175,091	$147	$25,702
VHA total	$352,666	$458,369	$478,522	$556,748	$605,047	$426,241	3,935,626	$147	$577,708

Note: Numbers may not add due to rounding.

Formulas for Equipment Distribution: $B_{eq}=V_{bc}*N_{eq}$

V_{bc} = Volume Basic and Complex Care patients

N_{eq} = National price for equipment = Budget for equipment (Beq) divided by Basic Care and Complex Care patients(V_{bc})

B_{eq} = Budget for equipment

NRM Distributions: Back-up data
($ in thousands)

Network	FY 1997 VERA NRM Distribution	FY 1998 VERA NRM Distribution	FY 1999 VERA NRM Distribution	FY 2000 VERA NRM Distribution	FY 2001 VERA NRM Distribution	FY 2002 VERA NRM Distribution	FY 2003 VERA Volume Basic and Complex (V_{bc})	Unadjusted FY 2001 Boeckh Index (BI)	Workload * BI	National Price	Budget based on Workload adjusted by Boeckh Index (Workload*BI* Price) (B_{nrm})
1 Boston	$15,259	$15,033	$14,767	$13,658	$14,040	$12,965	175,109	0.0214	3,748	$3,427	$12,847
2 Albany	$7,887	$7,952	$7,889	$7,412	$8,084	$7,787	107,777	0.0206	2,224	$3,427	$7,621
3 Bronx	$22,195	$22,403	$21,501	$19,648	$19,878	$17,913	164,079	0.0291	4,774	$3,427	$16,361
4 Pittsburgh	$15,219	$15,048	$15,399	$15,221	$17,108	$15,968	219,327	0.0208	4,568	$3,427	$15,657
5 Baltimore	$7,110	$6,989	$7,145	$6,642	$7,116	$6,704	105,532	0.0182	1,917	$3,427	$6,569
6 Durham	$8,277	$9,072	$8,953	$9,016	$10,165	$9,523	192,300	0.0143	2,755	$3,427	$9,441
7 Atlanta	$9,818	$10,515	$11,086	$10,734	$11,916	$11,612	234,272	0.0146	3,422	$3,427	$11,729
8 Bay Pines	$9,548	$10,797	$13,122	$14,125	$17,688	$17,669	350,987	0.0155	5,442	$3,427	$18,650
9 Nashville	$9,997	$9,994	$10,487	$10,217	$11,325	$10,796	193,165	0.0161	3,107	$3,427	$10,649
10 Cincinnati	$9,493	$9,572	$9,991	$10,041	$11,184	$10,301	140,680	0.0200	2,809	$3,427	$9,628
11 Ann Arbor	$11,488	$11,572	$12,093	$11,583	$12,643	$11,950	161,995	0.0219	3,546	$3,427	$12,152
12 Chicago	$16,913	$18,127	$17,067	$14,829	$14,261	$13,159	156,576	0.0226	3,544	$3,427	$12,145
15 Kansas City	$10,227	$10,449	$10,900	$10,393	$11,769	$11,405	159,466	0.0207	3,293	$3,427	$11,288
16 Jackson	$13,912	$13,893	$15,638	$16,287	$18,946	$18,052	354,220	0.0148	5,235	$3,427	$17,941
17 Dallas	$7,231	$7,189	$7,972	$8,318	$10,021	$9,747	189,625	0.0150	2,843	$3,427	$9,743
18 Phoenix	$5,808	$5,795	$7,367	$8,216	$10,269	$9,685	174,719	0.0161	2,820	$3,427	$9,666
19 Denver	$5,504	$5,468	$5,923	$5,704	$6,689	$6,361	109,622	0.0169	1,856	$3,427	$6,359
20 Portland	$11,317	$10,261	$11,711	$12,087	$13,994	$13,417	174,769	0.0220	3,840	$3,427	$13,160
21 San Francisco	$10,403	$10,324	$11,754	$12,522	$15,260	$14,724	176,242	0.0252	4,436	$3,427	$15,203
22 Long Beach	$15,816	$15,475	$16,504	$16,420	$18,564	$17,366	220,074	0.0223	4,897	$3,427	$16,784
23 Minneapolis	$12,230	$12,353	$12,290	$11,166	$11,543	$11,204	175,091	0.0373	3,289	$3,427	$11,273
VHA total	$235,653	$238,282	$249,562	$244,240	$272,463	$258,307	3,935,626	0.0000	74,365	$3,427	$254,865

Note: Numbers may not add due to rounding.

The Boeckh Index was applied separately to Networks 13 and 14 and the result summed for Network 23.

Formulas for NRM distribution: B_{nrm} = Workload*BI*National Price

B_{nrm} = NRM Budget = unadjusted Boeckh Index (BI) times Basic Care and Complex Care workload (Vbc) times National Price

National Price = Total Dollars available nationally divided by (sum of Network Basic Care and Complex Care workload times Network Boeckh Index)

FY 2003 VERA Outcome
($ in thousands)

Network	FY 2002	Total General Purpose	Increase	% Increase
1 Boston	$943,383	$1,012,354	$68,971	7.3%
2 Albany	$507,386	$556,418	$49,032	9.7%
3 Bronx	$1,058,664	$1,111,597	$52,933	5.0%
4 Pittsburgh	$955,780	$1,076,519	$120,739	12.6%
5 Baltimore	$575,640	$617,523	$41,882	7.3%
6 Durham	$881,606	$990,671	$109,066	12.4%
7 Atlanta	$1,071,956	$1,158,656	$86,699	8.1%
8 Bay Pines	$1,470,056	$1,655,761	$185,705	12.6%
9 Nashville	$848,607	$926,758	$78,151	9.2%
10 Cincinnati	$697,551	$771,274	$73,723	10.6%
11 Ann Arbor	$766,210	$849,127	$82,917	10.8%
12 Chicago	$898,572	$978,050	$79,478	8.8%
15 Kansas City	$717,747	$761,453	$43,707	6.1%
16 Jackson	$1,499,125	$1,688,502	$189,377	12.6%
17 Dallas	$850,104	$936,733	$86,629	10.2%
18 Phoenix	$731,784	$803,265	$71,481	9.8%
19 Denver	$483,243	$528,463	$45,220	9.4%
20 Portland	$840,081	$902,764	$62,683	7.5%
21 San Francisco	$947,781	$1,062,177	$114,396	12.1%
22 Long Beach	$1,082,849	$1,219,641	$136,791	12.6%
23 Minneapolis	$874,116	$917,822	$43,706	5.0%
VHA total	$18,702,243	$20,525,528	$1,823,285	9.7%

Note: Numbers may not add due to rounding.

FY 2002 General Purpose includes VERA adjustment for four networks, as well as all supplementals, World Trade Center Funding for VISN 3, and the Operational Shortfall for VISN 1.

FY 2003 Network Allocations
($ in thousands)

Network	Basic Care Allocation	Complex Care Allocation	High Cost Patients Allocation	Geographic Price Adjustment	Research Support Allocation	Education Support Allocation	Equipment Allocation	NRM Allocation	5% Capping Adjustment	Total General Purpose Allocations
1 Boston	$582,504	$234,721	$82,092	$20,663	$33,020	$20,802	$25,704	$12,847	$0	$1,012,354
2 Albany	$333,663	$155,865	$38,170	($8,841)	$4,416	$9,704	$15,821	$7,621	$0	$556,418
3 Bronx	$531,724	$255,407	$151,650	$58,275	$11,574	$24,350	$24,085	$16,361	$38,171	$1,111,597
4 Pittsburgh	$665,668	$277,264	$70,880	($7,092)	$15,286	$13,015	$32,195	$15,657	($6,352)	$1,076,519
5 Baltimore	$324,812	$178,101	$50,803	$12,610	$19,120	$10,016	$15,491	$6,569	$0	$617,523
6 Durham	$613,371	$262,148	$67,205	($17,524)	$12,862	$14,941	$28,228	$9,441	$0	$990,671
7 Atlanta	$726,327	$289,513	$78,849	($18,557)	$18,524	$17,882	$34,389	$11,729	$0	$1,158,656
8 Bay Pines	$1,162,862	$405,117	$79,851	($65,567)	$13,082	$22,825	$51,521	$18,650	($32,580)	$1,655,761
9 Nashville	$622,951	$210,603	$40,105	($21,979)	$14,025	$22,048	$28,355	$10,649	$0	$926,758
10 Cincinnati	$436,754	$231,570	$51,330	($2,511)	$13,314	$10,538	$20,650	$9,628	$0	$771,274
11 Ann Arbor	$523,155	$195,204	$65,666	($750)	$17,096	$12,825	$23,779	$12,152	$0	$849,127
12 Chicago	$502,403	$285,850	$88,926	$17,963	$21,395	$26,386	$22,984	$12,145	$0	$978,050
15 Kansas City	$514,648	$179,915	$31,584	($17,326)	$4,543	$13,395	$23,408	$11,288	$0	$761,453
16 Jackson	$1,137,590	$360,498	$88,477	($15,210)	$20,188	$27,533	$51,996	$17,941	($510)	$1,688,502
17 Dallas	$577,216	$258,775	$54,090	($20,396)	$15,791	$13,678	$27,835	$9,743	$0	$936,733
18 Phoenix	$560,008	$172,992	$33,445	($20,479)	$9,371	$12,614	$25,647	$9,666	$0	$803,265
19 Denver	$344,276	$118,540	$30,031	($4,045)	$7,721	$9,490	$16,091	$6,359	$0	$528,463
20 Portland	$534,573	$233,788	$57,894	$3,459	$22,969	$11,266	$25,654	$13,160	$0	$902,764
21 San Francisco	$552,476	$231,202	$91,593	$78,752	$50,710	$16,371	$25,870	$15,203	$0	$1,062,177
22 Long Beach	$692,294	$278,530	$97,048	$34,901	$50,170	$29,777	$32,305	$16,784	($12,170)	$1,219,641
23 Mineapolis	$539,377	$247,593	$45,445	($6,347)	$25,198	$16,141	$25,702	$11,273	$13,440	$917,822
VHA totals	$12,478,652	$5,063,194	$1,395,135	$0	$400,375	$355,599	$577,708	$254,865	($0)	$20,525,528

Note: Numbers may not add due to rounding.

FY 2003 Calculation of Case Mix Index for Basic and Complex Care

($ in millions)

Network	Basic Care Allocation (including Non Vested)	Basic Care High Cost Payments	Total Basic Care Funding (including High Cost)	Basic Care Workload	Basic Care Average Price	Basic Care Case Mix Index	Complex Care Allocation	Complex Care High Cost Payments	Complex Care Total Funding (including High Cost)	Complex Care Workload	Complex Care Average Price	Complex Care Case Mix Index	Total Funding (Basic Care Plus Complex Care Allocation including High Cost)	Total Basic Care and Complex Care Workload	Total Average Price	Total Case Mix Index
1 Boston	$583	$14	$597	168,178	$3,547	1.05	$235	$68	$303	6,930	$43,684	1.10	$899	175,109	$5,136	1.07
2 Albany	$334	$6	$340	102,723	$3,307	0.98	$156	$32	$188	5,054	$37,191	0.93	$528	107,777	$4,896	1.02
3 Bronx	$532	$29	$560	155,915	$3,594	1.07	$255	$123	$378	8,164	$46,361	1.16	$939	164,079	$5,722	1.19
4 Pittsburgh	$666	$12	$678	211,533	$3,204	0.95	$277	$59	$336	7,795	$43,113	1.08	$1,014	219,327	$4,622	0.96
5 Baltimore	$325	$7	$332	99,953	$3,317	0.98	$178	$44	$222	5,579	$39,823	1.00	$554	105,532	$5,247	1.09
6 Durham	$613	$8	$621	184,527	$3,365	1.00	$262	$60	$322	7,773	$41,397	1.04	$943	192,300	$4,902	1.02
7 Atlanta	$726	$19	$745	224,880	$3,313	0.98	$290	$60	$350	9,392	$37,219	0.93	$1,095	234,272	$4,673	0.97
8 Bay Pines	$1,163	$11	$1,174	337,811	$3,475	1.03	$405	$69	$474	13,176	$35,975	0.90	$1,648	350,987	$4,695	0.98
9 Nashville	$623	$10	$633	186,779	$3,387	1.01	$211	$30	$241	6,386	$37,740	0.95	$874	193,165	$4,523	0.94
10 Cincinnati	$437	$10	$446	133,592	$3,341	0.99	$232	$42	$273	7,088	$38,571	0.97	$720	140,680	$5,116	1.06
11 Ann Arbor	$523	$10	$533	156,100	$3,416	1.01	$195	$56	$251	5,895	$42,549	1.07	$784	161,995	$4,840	1.01
12 Chicago	$502	$14	$517	148,186	$3,486	1.03	$286	$75	$361	8,390	$42,981	1.08	$877	156,576	$5,602	1.16
15 Kansas City	$515	$7	$522	153,763	$3,396	1.01	$180	$24	$204	5,704	$35,773	0.90	$726	159,466	$4,554	0.95
16 Jackson	$1,138	$22	$1,160	343,040	$3,381	1.00	$360	$66	$427	11,180	$38,169	0.96	$1,587	354,220	$4,479	0.93
17 Dallas	$577	$11	$588	182,163	$3,227	0.96	$259	$44	$302	7,462	$40,515	1.02	$890	189,625	$4,694	0.98
18 Phoenix	$560	$6	$566	169,178	$3,345	0.99	$173	$28	$201	5,541	$36,193	0.91	$766	174,719	$4,387	0.91
19 Denver	$344	$6	$350	105,801	$3,308	0.98	$119	$24	$143	3,821	$37,380	0.94	$493	109,622	$4,496	0.93
20 Portland	$535	$13	$547	167,429	$3,269	0.97	$234	$45	$279	7,340	$38,012	0.95	$826	174,769	$4,728	0.98
21 San Francisco	$552	$13	$566	169,105	$3,345	0.99	$231	$78	$310	7,137	$43,381	1.09	$875	176,242	$4,966	1.03
22 Long Beach	$692	$20	$712	211,466	$3,367	1.00	$279	$77	$356	8,608	$41,335	1.04	$1,068	220,074	$4,852	1.01
23 Minneapolis	$539	$7	$546	167,766	$3,255	0.97	$248	$39	$286	7,325	$39,092	0.98	$832	175,091	$4,754	0.99
VHA Totals	$12,479	$253	$12,731	3,779,887	$3,368	1.00	$5,063	$1,143	$6,206	155,739	$39,848	1.00	$18,937	3,935,626	$4,812	1.00

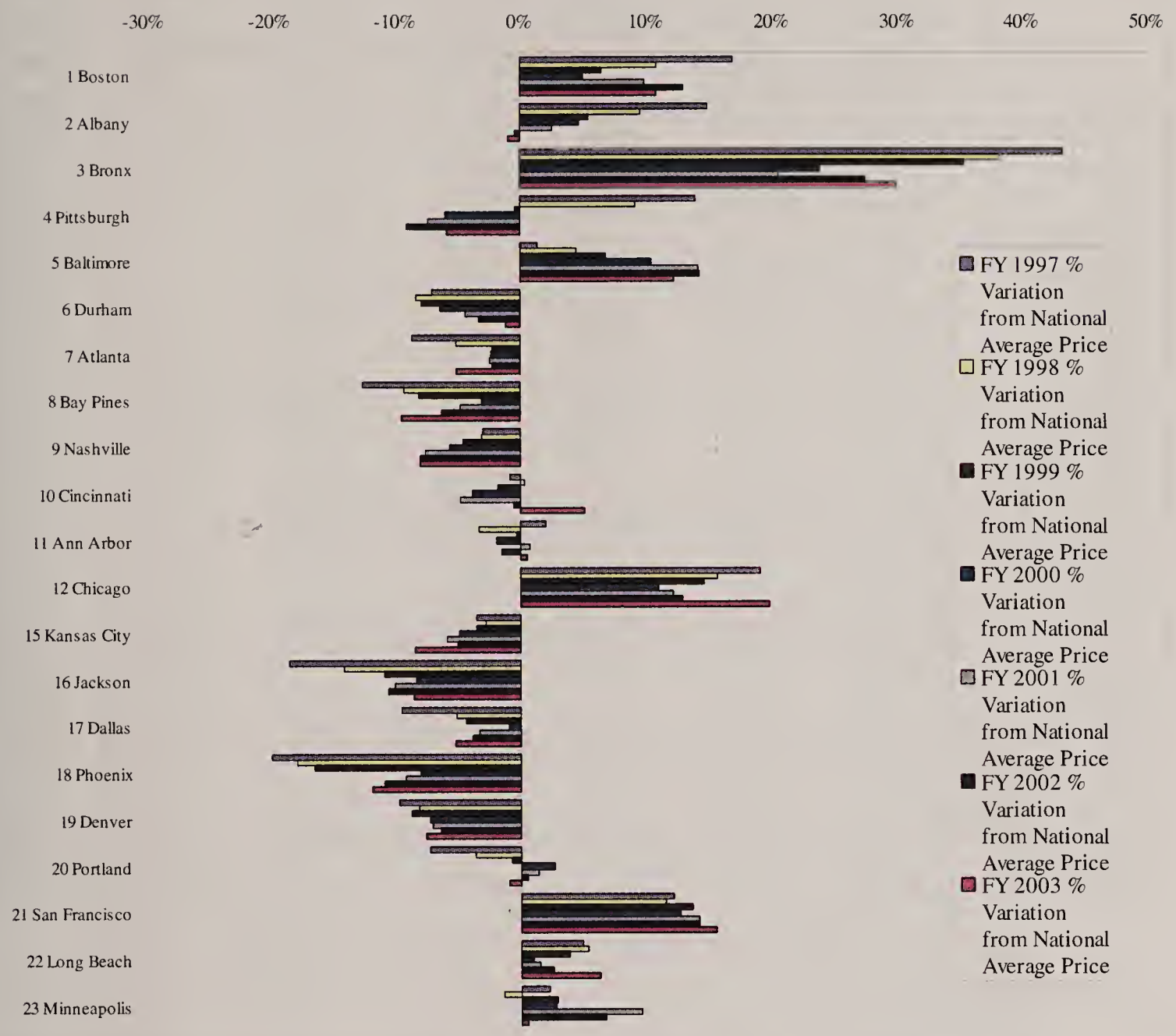
Average Price = Total Funding divided by the Workload.
Case Mix Index = Network Average Price divided by the National Average Price.

A case mix of 1.10, for example, indicates that the Network's patients in that price group, or in total, are on the average priced 10% above than the national average; a case mix of 0.95 indicates that the Network's patients in that price group, or in total, are on the average, priced 5% lower than the national average.

If a network has both Basic Care and Complex Care Case Mix below the national average, but a Total Case Mix above the national average, it means that while their Basic Care and Complex Care patients are priced below the national average, their proportion of Complex Care patients to Basic Care patients is higher than average.

Note: The numbers may not add due to rounding.

Percent Variation from National Average: VERA Network
Average Price including, caps and adjustments
FY 1997 to FY 2003



Network Percent Variation from VERA National Average Price, including caps and adjustments, FY 1997 to FY 2003							
Network	FY 1997 % Variation from National Average Price	FY 1998 % Variation from National Average Price	FY 1999 % Variation from National Average Price	FY 2000 % Variation from National Average Price	FY 2001 % Variation from National Average Price	FY 2002 % Variation from National Average Price	FY 2003 % Variation from National Average Price
1 Boston	16.9%	10.9%	6.5%	5.0%	9.9%	12.9%	10.9%
2 Albany	15.0%	9.5%	5.5%	4.7%	2.5%	-0.5%	-1.0%
3 Bronx	43.2%	38.3%	35.4%	23.9%	20.6%	27.4%	29.9%
4 Pittsburgh	13.9%	9.1%	-0.5%	-6.1%	-7.4%	-9.1%	-5.9%
5 Baltimore	1.4%	4.5%	6.8%	10.4%	14.2%	14.3%	12.2%
6 Durham	-7.1%	-8.3%	-8.0%	-6.4%	-4.4%	-3.3%	-1.2%
7 Atlanta	-8.6%	-5.2%	-2.3%	-2.4%	-2.5%	-2.3%	-5.2%
8 Bay Pines	-12.6%	-9.3%	-8.1%	-3.1%	-4.8%	-6.3%	-9.5%
9 Nashville	-3.0%	-3.1%	-4.6%	-5.7%	-7.6%	-8.0%	-8.0%
10 Cincinnati	-0.9%	0.3%	-1.9%	-3.8%	-4.9%	-0.6%	5.1%
11 Ann Arbor	2.0%	-3.4%	-0.3%	-2.0%	0.7%	-1.5%	0.5%
12 Chicago	19.0%	15.6%	14.6%	10.9%	12.1%	12.9%	19.8%
15 Kansas City	-3.6%	-2.8%	-3.5%	-4.9%	-5.9%	-5.0%	-8.4%
16 Jackson	-18.4%	-14.1%	-10.9%	-8.4%	-10.0%	-10.6%	-8.6%
17 Dallas	-9.5%	-5.1%	-4.4%	-1.0%	-3.3%	-3.9%	-5.3%
18 Phoenix	-19.9%	-17.9%	-16.4%	-8.0%	-9.2%	-10.9%	-11.8%
19 Denver	-9.7%	-8.1%	-8.7%	-7.2%	-7.1%	-6.4%	-7.6%
20 Portland	-7.3%	-3.7%	-0.8%	2.6%	1.4%	0.5%	-1.0%
21 San Francisco	12.2%	11.5%	13.6%	12.7%	14.2%	14.2%	15.6%
22 Long Beach	4.9%	5.3%	3.8%	0.9%	1.5%	2.5%	6.3%
23 Minneapolis	2.2%	-1.4%	2.8%	2.8%	9.6%	6.7%	0.5%
VHA Totals	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

VERA General Purpose Allocations and Receipts include funds for special programs and facility maintenance
(Dollars in millions)

Network	VERA General Purpose Plus Receipts	AIDS/HIV	Blind Rehabilitation	Geriatrics & Extended Care (LTC)	Gulf War	Hepatitis C	Homeless	Pharmacy	Post Traumatic Stress Disorder	Seriously Mentally Ill	Spinal Cord Injury	Substance Abuse	Women Veterans	Facility Maintenance
1 Boston	$1,092	$15	$4	$169	$16	$5	$71	$154	$4	$103	$13	$21	$1	$140
2 Albany	$599	$9	$2	$102	$9	$3	$42	$92	$2	$61	$8	$13	$1	$84
3 Bronx	$1,200	$14	$3	$163	$15	$5	$68	$148	$4	$99	$13	$20	$1	$135
4 Pittsburgh	$1,177	$17	$4	$196	$18	$6	$82	$177	$5	$118	$15	$25	$2	$161
5 Baltimore	$661	$9	$2	$104	$10	$3	$44	$95	$2	$63	$8	$13	$1	$86
6 Durham	$1,092	$16	$4	$182	$17	$6	$76	$165	$4	$110	$14	$23	$1	$150
7 Atlanta	$1,248	$18	$4	$211	$20	$6	$88	$191	$5	$128	$16	$26	$2	$174
8 Bay Pines	$1,822	$28	$7	$325	$30	$10	$136	$295	$8	$197	$25	$41	$3	$268
9 Nashville	$1,014	$15	$4	$173	$16	$5	$72	$157	$4	$105	$13	$22	$1	$143
10 Cincinnati	$819	$12	$3	$139	$13	$4	$58	$126	$3	$84	$11	$17	$1	$114
11 Ann Arbor	$931	$13	$3	$149	$14	$5	$62	$135	$4	$90	$12	$19	$1	$123
12 Chicago	$1,063	$14	$3	$163	$15	$5	$68	$148	$4	$99	$13	$21	$1	$135
15 Kansas City	$836	$12	$3	$144	$13	$4	$60	$131	$3	$87	$11	$18	$1	$119
16 Jackson	$1,821	$27	$6	$311	$29	$9	$130	$282	$7	$188	$24	$39	$2	$256
17 Dallas	$1,014	$15	$4	$173	$16	$5	$73	$157	$4	$105	$13	$22	$1	$143
18 Phoenix	$874	$13	$3	$152	$14	$5	$64	$138	$4	$92	$12	$19	$1	$125
19 Denver	$580	$8	$2	$96	$9	$3	$40	$87	$2	$58	$7	$12	$1	$79
20 Portland	$971	$14	$3	$159	$15	$5	$67	$145	$4	$96	$12	$20	$1	$131
21 San Francisco	$1,122	$14	$3	$163	$15	$5	$68	$147	$4	$98	$13	$20	$1	$134
22 Long Beach	$1,275	$17	$4	$201	$19	$6	$84	$183	$5	$122	$16	$25	$2	$166
23 Minneapolis	$1,031	$14	$3	$163	$15	$5	$68	$148	$4	$99	$13	$20	$1	$135
VHA Totals	$22,243	$314	$76	$3,638	$337	$111	$1,522	$3,301	$87	$2,203	$281	$456	$29	$3,000

Note: Numbers may not add due to rounding. Columns presented are not mutually exclusive. For example, Pharmacy and Facility Maintenance are included in programs such as AIDS/HIV, PTSD, etc. Also, funding for these programs includes both VERA General Purpose funds as well as receipts.

VHA totals are amounts in volume 2 of the President's FY 2003 budget on p. 2-108. Funding for receipts are also derived from the FY 2003 President's Budget.

This table takes the total VHA program funds and distributes them to each network based on VERA workload.

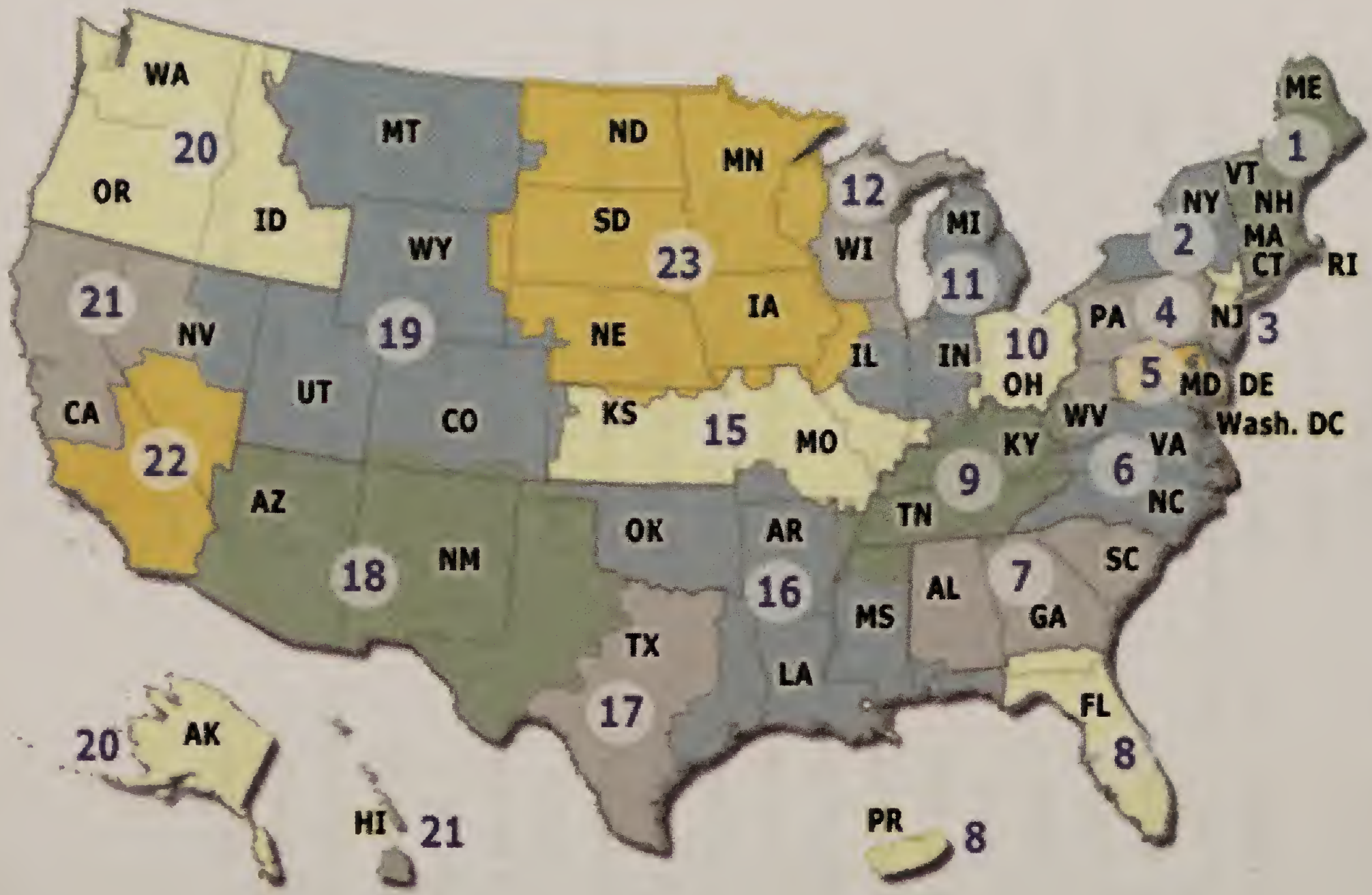
This information sets neither a program floor nor ceiling for network expenditures in these programs. Rather it illustrates that funds are allocated for these purposes according to the budget, and these funds are included in the overall resources available to networks (VERA General Purpose and Receipts).

Appendix 2

The Veterans Integrated Service Networks

Network	States
1 Boston	Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, Vermont
2 Albany	New York
3 Bronx	New York, New Jersey
4 Pittsburgh	Pennsylvania, Delaware, West Virginia
5 Baltimore	Maryland, District of Columbia, West Virginia
6 Durham	North Carolina, Virginia, West Virginia
7 Atlanta	Georgia, Alabama, South Carolina
8 Bay Pines	Florida, Puerto Rico
9 Nashville	Tennessee, Kentucky, West Virginia
10 Cincinnati	Ohio
11 Ann Arbor	Michigan, Illinois, Indiana
12 Chicago	Illinois, Michigan, Wisconsin
15 Kansas City	Missouri, Illinois, Kansas
16 Jackson	Mississippi, Arkansas, Louisiana, Oklahoma, Texas
17 Dallas	Texas
18 Phoenix	Arizona, New Mexico, Texas
19 Denver	Colorado, Montana, Utah, Wyoming
20 Portland	Oregon, Alaska, Idaho, Washington
21 San Francisco	California, Hawaii, Nevada, Philippines
22 Long Beach	California, Nevada
23 Minneapolis	Minnesota, North Dakota, South Dakota, Nebraska, Iowa

21 Veterans Integrated Service Networks



Appendix 3

History: Previous Allocation Models, Changes to VERA, Results, VERA Supplemental Adjustments and Previous Assessments

Previous Allocation Models

Since 1985, VA has used four funding allocation systems, including VERA. These systems are briefly discussed below. In general, the previous VA funding allocation systems perpetuated funding imbalances across the country, and they were too complex. This led to:

- dollars being spent inefficiently in some facilities, resulting in limited access and services at other facilities, and
- loss of credibility because the systems were too difficult to understand.

Resource Allocation Methodology (1985 – 1990)

From FY 1985 to FY 1990, VA operated a Diagnosis Related Groups (DRG)-based Resource Allocation Methodology (RAM). RAM made retrospective adjustments to a facility's current year operating budget based on 2-year old workload and performance data. The RAM system rewarded facilities for performing as many medical procedures as possible. Under RAM, VA medical centers had incentives to perform work beyond their resources because increases in the number of patients treated or procedures performed resulted in increased funding.

Resource Planning and Management (1990 – 1996)

During the late summer 1990, VA began moving to a new prospective, patient-based system along the lines of what private-sector health care was doing. The private sector was increasing the emphasis on primary care and preventive services, shifting medical and surgical treatment from inpatient to ambulatory settings, reducing lengths of hospital stays, and adopting a managed care approach to the operation of large health care organizations. VA's patient-based resource allocation system, known as Resource Planning and Management (RPM), was initiated for budget allocation purposes in FY 1994 and modified for use in FY 1995, based upon refinements suggested from operational experience and clinical input.

The system was highly complex. In the end, the model and the process to negotiate final budget allocations proved to be too complex and onerous to effectively and credibly allocate resources. In addition, RPM was not created to fund all facilities at a nationally adjusted average price. This perpetuated the inequities in funding, efficiency, and access that already existed in the VA health care system.

Even though the old systems were not used to shift resources across the country to correct funding imbalances, the data available from these systems demonstrated that such shifts were needed. For example, if RAM had been allowed to run without limits or caps, the systemwide shifting of dollars would have been more than $200 million in any one year.

Blended Rates (1996 – First step to national adjusted prices)

During FY 1996, under a methodology known as "blended rates", VA made an initial move toward a national pricing system by combining the local VA medical center's historical costs with the national, network and peer group facility cost. For transition in FY 1996, the blend of the rate structure was heavily weighted toward facilities' historical costs - that is, the FY 1996 blend was weighted at 70% for the facility rate and only 20% for the national rate. The peer group and network rates were 5% each.

In FY 1996, the blended rates model called for a shift of $150 million from high-cost networks to low-cost networks; however, due to the system's instability during network formation and development, reserve funds were used to minimize the shift among networks. The net effect of the shift of resources systemwide in FY 1996 was approximately $23 million.

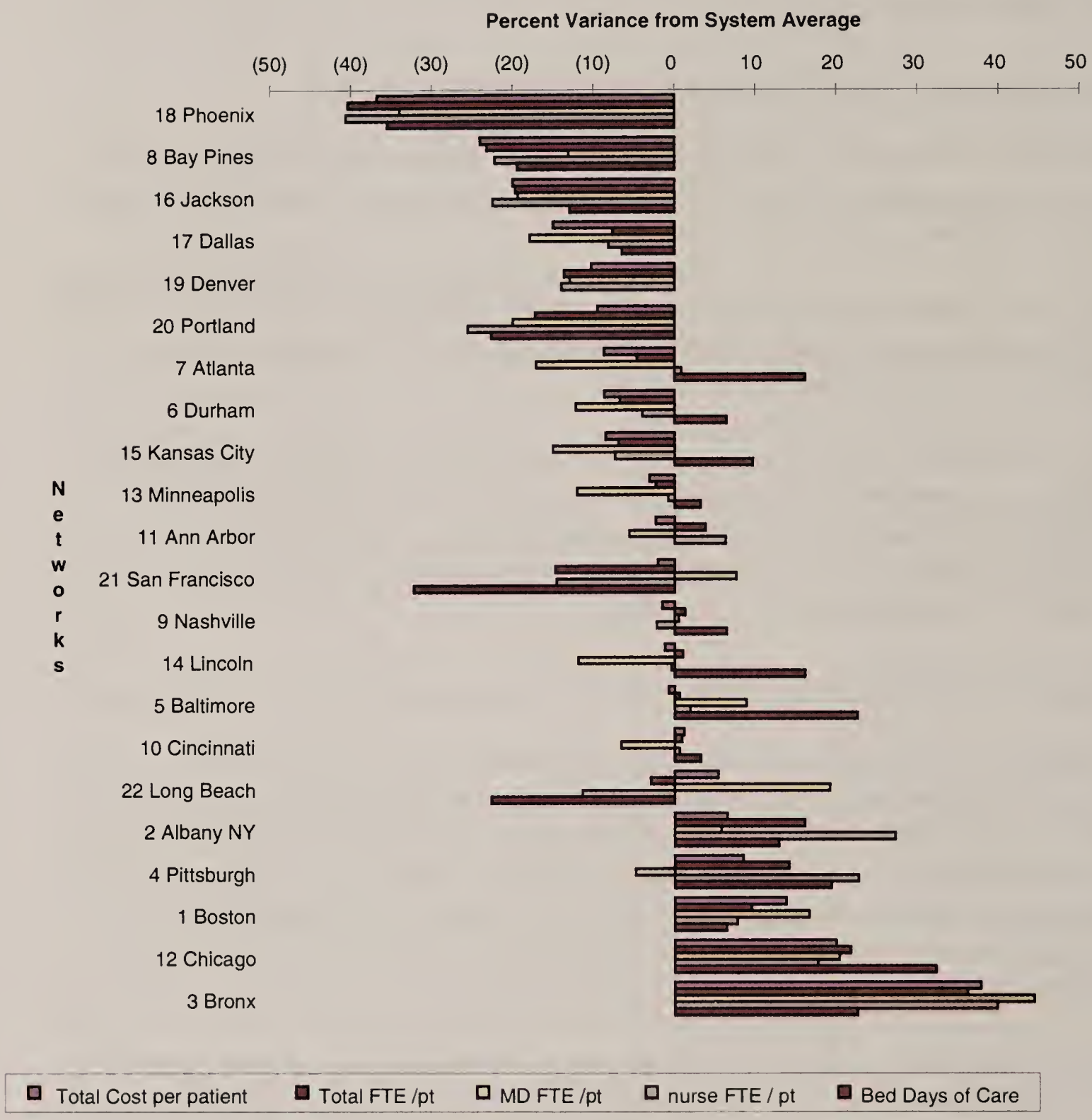
Measuring Funding Imbalances

In simple terms, "funding imbalances" or "funding inequities" occur when one network has more funding than another network, after adjusting for labor and other uncontrollable costs, and patient workload. In 1996, GAO noted, "While considerable numbers of veterans have migrated to southeastern and southwestern states, there was little shift in VA resources. As a result, facilities mainly in the eastern states were more likely to have adequate resources to treat all veterans seeking care than other facilities."

The historic funding imbalances can be measured through various indicators of resource consumption. Those data include total costs per patient, number of staff per patient, and bed days of care per patient. Some of these measures are presented in Figure 9 on page 92.

Figure 9 shows that in several critical indicators of resource consumption, the Boston, Albany, Bronx, Pittsburgh and Chicago Networks (Networks 1, 2, 3, 4 and 12) significantly exceeded the VA national averages. Networks 13 and 14 were not consolidated until FY 2002. These per patient indicators show that these networks were higher in total costs, total staff, physician staff, nurse staff, and bed days of care.

Figure 9: Historic resource consumption per patient
(Based on FY 1995 data)



The funding imbalances that were perpetuated by the old systems were also recognized by GAO in a report to Congress in February 1996. GAO concluded that "the [old] resource allocation system . . . produces data that point to potential inequities so that VA can better link resources to facility workloads. However, VA has not yet used the system for this purpose." As a result, GAO also concluded that "inconsistencies remain in veterans' access to care across the VHA

system." They noted "the facilities in the eastern states were more likely to have adequate resources to treat all veterans seeking care than other facilities and, the [RPM] system does not distinguish between facilities' discretionary and mandatory workload." The report recommended that VA pursue its plans to improve the equity of its allocations, and stated: "We considered the following two elements to be characteristics of an equitable system:

- It provides comparable resources for comparable workload.
- It provides resources so that veterans within the same priority categories have the same availability of care, to the extent practical, throughout the VA health care system."

GAO reviewed the projected change in veteran population by state, 1989 to 2000, and noted that "although the overall veteran population has decreased, veterans have been migrating from northeastern and midwestern states to southeastern and southwestern states."

GAO recognized that while VA had been advancing its workload and expenditure measurement analysis capability, it had not moved forward aggressively in the past with RAM and RPM to implement the full impact of the resource allocation changes that these systems demonstrated. As a result, the old systems perpetuated funding imbalances across the country in the VA system.

VERA 1997 to Present

Network allocations under VERA are made in a manner that recognizes there are legitimate and unavoidable variances among networks in the costs of providing care. These variances include the health care needs of our patients, the cost of labor in different parts of the country, and the level of support devoted to our research and education missions. The complexities of the veterans' health care system are discussed on page 1. The VERA system addresses these complexities and, as a result, each network's average price will vary from the national average. VERA only indicates the need for funding shifts when high or low network costs are not explained by the system's complexities. Figure 5 on page 28 shows the projected average price each network is paid under the VERA model in FY 2003. Figure 8 on page 37 shows the overall result from FY 1996 to FY 2001 on how total available funds (i.e., VERA allocations, specific purpose allocations, collection revenues, and reimbursements) were spent, that is, the percent variance from the national average for each network's total dollars per patient in FYs 1996 – 2001.

VERA also accounts for veterans who receive care in more than one network during the year – i.e., veterans who receive "care across networks". This includes

the veterans who are commonly known as "snowbirds". Network budgets are adjusted based on the historical usage patterns and costs for these veterans in more than one network.

In addition to adjustments for labor, contracts, care in more than one network, and the highest cost patients, VERA adjusts for four other factors: research support, education support, equipment, and non-recurring maintenance. These adjustments recognize that the level of research and education support, as well as the need for equipment and non-recurring maintenance, is not the same among the networks. VERA begins with the Basic Care and Complex Care prices and adjusts each network's budget for the components discussed above. As a result, each network receives a budget that recognizes its individual characteristics.

Goals of VERA

VERA was created to address the problems of the previous systems and support VA's goals of:

- treating the greatest number of veterans having the highest priority for health care,
- allocating funds fairly according to the number of veterans having the highest priority for health care,
- recognizing the special health care needs of veterans,
- creating an understandable funding allocation system that results in having a reasonably predictable budget,
- aligning resource allocation policies to the best practices in health care,
- improving the accountability in expenditures for research and education support, and
- complying with the congressional mandate.

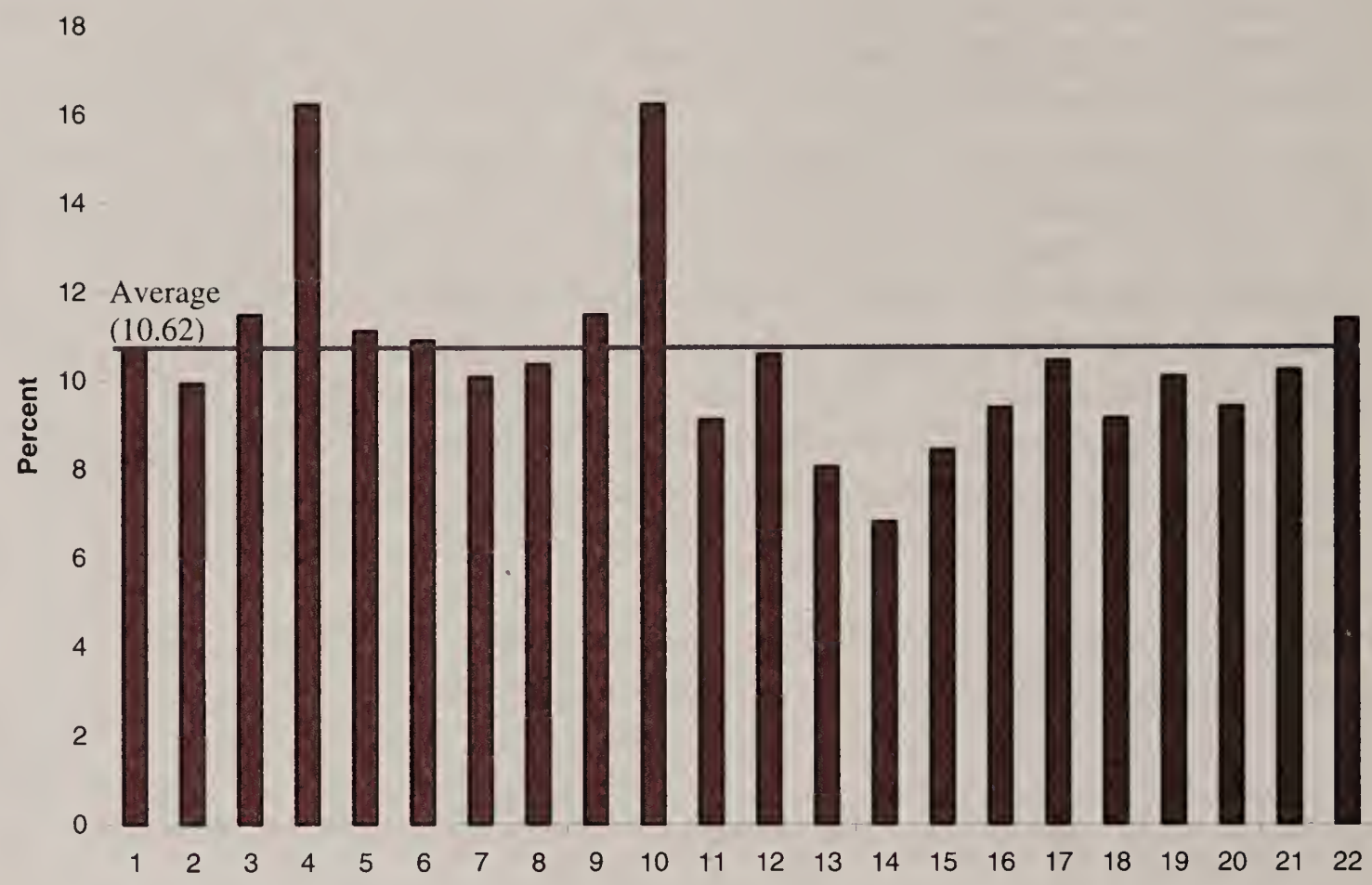
VERA achieves these objectives and, at the same time, strikes a balance between simplifying resource allocation and recognizing the complexities of the veterans' health care system. For example, the VERA methodology recognizes that VA treats two general sets of patients – those with "routine" health care needs (Basic Care) and those with complex and typically chronic health care needs (Complex Care). Examples of Complex Care include spinal cord injury, long-term care, blind rehabilitation, chronic mental illness, end stage renal disease, and advanced AIDS.

Changes to VERA FY 1998 to FY 2002

There were no significant VERA changes from FY 1997 to 1998. In FY 1999, the following changes were made to the VERA model. A second lower-cost Basic Care classification category for single outpatient visits was established. What was formerly known as Special Care was renamed "Complex" Care. Funding to support Research was based on a new formula that rewarded VA administered research. Equipment and NRM formulas began changing in a phased manner to more fully utilize patient care workload (Basic and Complex Care) as the basis of those models. The geographic price adjustment was changed to use the most recent and accurate data available to properly reflect the considerable efforts to manage their manpower expenditures. To that end, the labor index in the FY 1999 VERA model was based on the most recent pay periods during FY 1998. Also in FY 1999, the geographic price adjustment did not include the effect of holiday, standby and overtime pay that reflected more truly the network's controllable workload.

History of Single Visit, Non-Vesting and Vesting in Basic Care: Figure 10 shows the Basic single outpatient visit patients who used VA one time between FY 1995 and FY 1997, as a percentage of Basic Care workload during this period. Networks 13 and 14 were not consolidated until FY 2002. This is consistent with the Basic single outpatient visits and Basic Care workload presented in the FY 1999 VERA book. Figure 10 depicts that Networks 4 and 10 had a significantly higher percentage of Basic single outpatient visits (both 16.2%) compared to the system wide average of 10.62%. If this trend continued, or increases of this nature throughout the system were unchecked, they would pull funding away from more expensive Basic Care workload. There was concern that the Basic single outpatient visits should not be funded at the national Basic Care price because that would provide financial incentives to see relatively healthy patients only once at the expense of more appropriate activities. Therefore, for FY 1999, a new price group was established for Basic single outpatient visits, with a national price per patient based on cost. The national Basic single outpatient visit price for FY 1999 was $66. For the FY 2000 allocation, VHA established criteria for a vested patient even with one visit, and those patients are funded at the full Basic Vested Care price.

Figure 10: Basic Single Outpatient Visits as Percent of 3-Year Basic Workload, by Network, FY 1995 - FY 1997



In FY 2000, the Basic Care group was divided into two sub-components: Basic Vested Care and Basic Non-Vested Care. Basic Vested Care patients are those who rely on VA for their care. Basic Non-Vested Care patients are those who use some VA health care services but are less reliant on the VA system. This process replaced the Basic Care single outpatient visit distinction that was used in the FY 1999 allocation. Instead of identifying the low cost Basic Care price group strictly on utilization (one outpatient visit during the three year period), the intention was to identify the patients who were likely to have limited use of the VA in the future, the Basic Care non-vested patients. A patient is considered vested in the veterans' health care system if the patient used inpatient services or received an appropriate, detailed medical evaluation during the past three years. This medical evaluation is determined through the presence of an appropriate CPT code. By applying relevant CPT codes to outpatients seen in Fiscal Years 1996, 1997, and 1998, and counting the inpatients for those same years, vested patients were identified for the FY 2000 VERA.

Figure 11 depicts the percent of the Basic Care patients for each network who are single outpatient visits, and those who are non-vested using the new definition for

the time period FY 1996 through FY 1998. Networks 13 and 14 were not consolidated until FY 2002. It shows that for this time period, nationally, 11.6% of the Basic patients were single outpatient visits (seen only once in the three-year period), and 18.1% of the Basic Care patients were non-vested. There are differences among networks in the percent of single outpatient visits or non-vested Basic Care patients. Networks 4 and 10 had a significantly higher percentage of Basic single outpatient visits. They also have the highest percents for the Basic Non-Vested patient counts. Generally, networks that had a relatively high percentage of single outpatient visits also have a relatively high percentage of non-vested patients. The price for the Basic Care non-vested patients is based on costs, consistent with the methodology used to establish the FY 1999 price for the single outpatient visits. The national Basic Care non-vested price for FY 2000 was $105.

Figure 11: Basic Single Outpatient Visits and Non-Vested Workload as Percent of 3-Year Basic Workload, by Network, FY 1996 - FY 1998

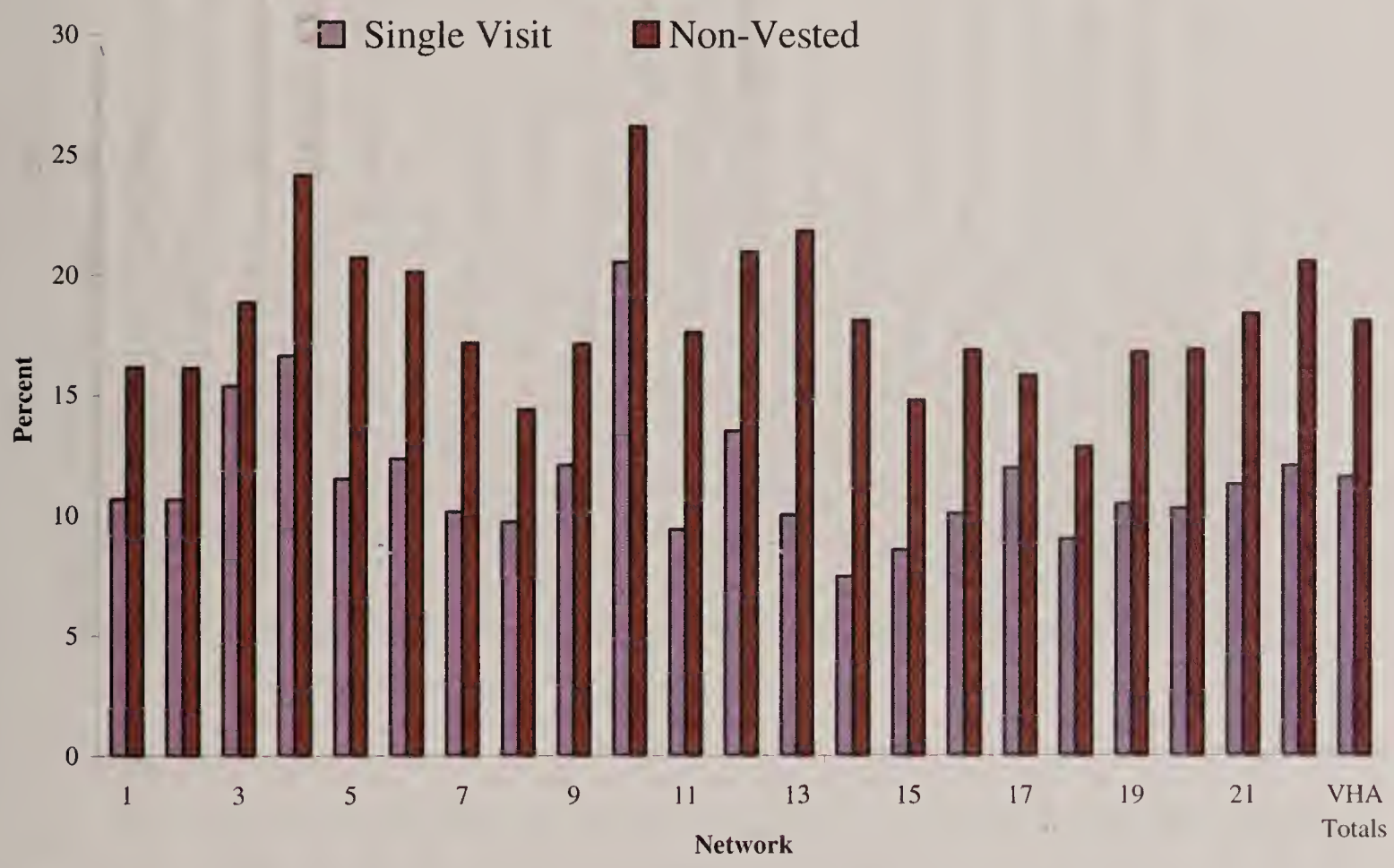
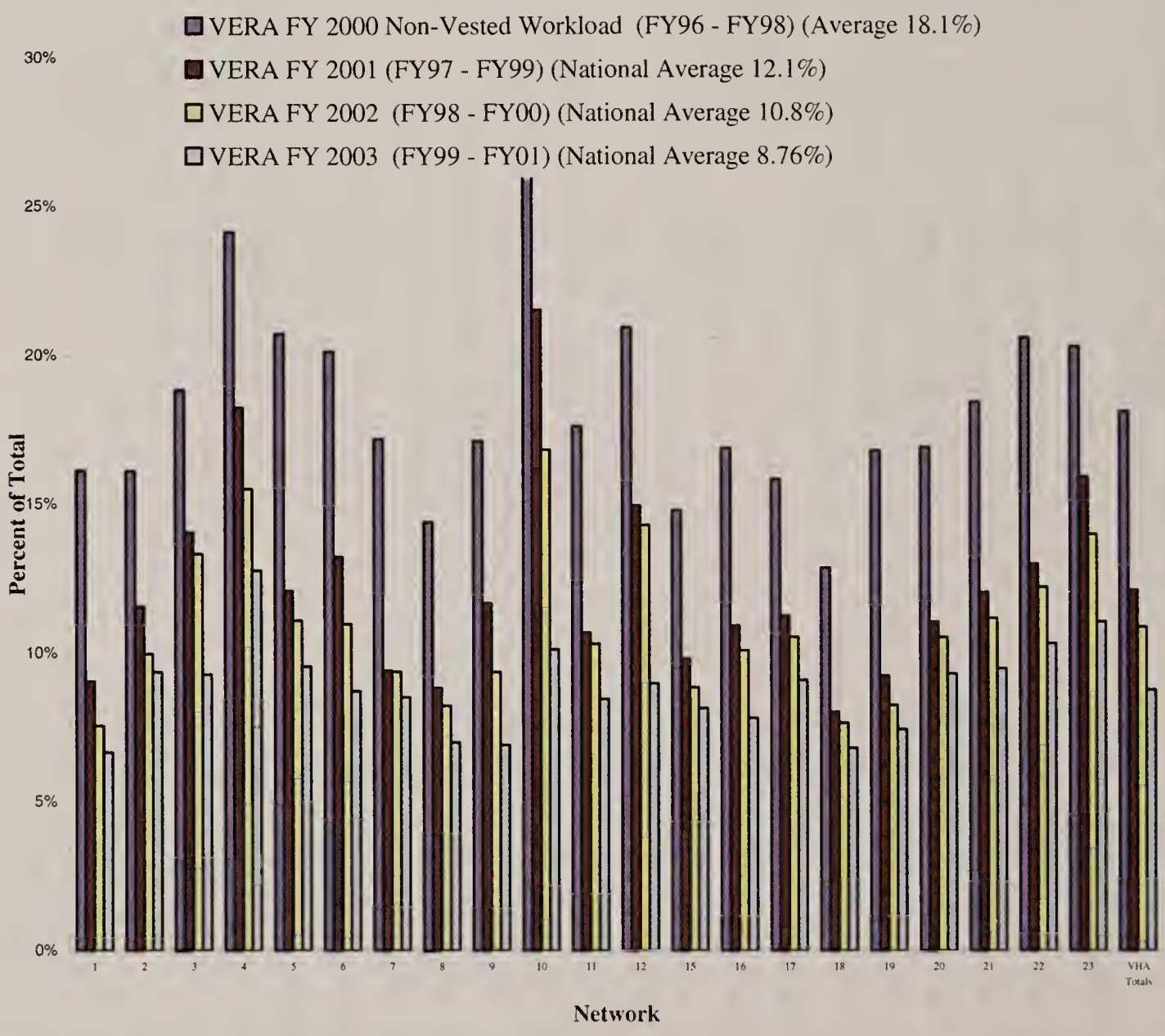


Figure12 shows the percent of Basic Non-Vested as a percent of total Basic Care workload by network for the three-year VERA time periods for FY 2000 (FY 1996 through FY 1998), FY 2001 (FY 1997 through FY 1999), FY 2002 (FY 1998 through FY 2000) and FY 2003 (FY 1999 through FY 2001). It shows for these time periods, nationally, the Basic Non-Vested workload decreased from

18.1% to 12.1% to 10.9% to 8.8%. For the FY 2003 VERA time period Networks 4 (12.8%) and 10 (10.1%), while decreasing their percentage of Basic Non-Vested workload from the FY 2002 time period, continue to have a higher than average percentage than all the other networks with the exception of Network 23 (second highest for FY 2003 at 11.1%) and Network 22 (third highest for FY 2003 at 10.3%).

Figure 12: Non-Vested Workload as Percent of 3-Year Basic Workload, by Network



FY 2000 Patient Classification Workload Changes: In the spring of 1998, the VHA CFO established the VERA Patient Classification Workgroup. The mission of this workgroup was to review the patient classification structure and recommend improvements as needed. When the workgroup began, there were 25 Basic Care Group classes and 29 Special Care Group classes, with a VERA price in the allocation system for each of the two groups. As a result of their review, in FY 2000 there were 18 Basic Care classes, and 24 Complex Care classes (in FY 2003 this has changed to 21 Basic Care classes and 26 Complex Care classes) in the VERA methodology. The workgroup recommended the following series of

patient classification workload refinements that were approved for implementation beginning in the FY 2000 allocation process.

1. The four Transplant VERA Classes, (Heart/Lung, Liver, Kidney, and Bone Marrow) were combined into one class, and this class was revised from a one-year designation to a three-year designation. The move to a three-year designation recognized the extreme high cost of transplants that continues beyond the initial procedure year.

2. Compensation and Pension (C&P) Exam patients are funded workload in VERA, with assignment to the VERA Price Group indicated by their levels of care and the title of the VERA Class "One Administrative Visit" was changed to "Compensation and Pension Exams."

3. The Blind Rehabilitation VERA Patient Class was converted from a three-year designation to a one-year designation. This was done because the average cost of caring for a Blind Rehabilitation patient declines significantly after the first year and the cost in the following years is not necessarily associated with the treatment provided in a Blind Rehabilitation center or the patient's blind condition.

4. The VERA Patient Class, "End Stage Renal Disease, (ESRD) – Home Care," was combined with the ESRD Class, and contract workload for patients in this class is now captured for VERA funding.

5. Collateral Visits are no longer funded in VERA. In prior years a collateral (someone associated with a veteran receiving VA health care) visit was counted and included in some cases as Complex Care workload. Now collateral visits do not qualify as VERA workload.

6. All workload associated with Home Care is considered the same without regard to provider source or designation.

7. The four HIV/AIDS classes were redefined into two classes: one for Complex Care related to infection or malignancy (current Category 4 definition) and patients who are on specific antiretroviral HIV medications; and one for Basic Care (all other HIV cases).

8. All VERA outpatient classes were eliminated (High Medical, High Rehabilitation, Standard Outpatient, Standard Outpatient greater than 12 visits, and Day Psychiatry Care), and those patients are now assigned to one of the remaining VERA classes.

9. The VERA patient class "Alcohol and Drug Abuse" was renamed "Addictive Disorders."

FY 2001 Patient Classification Workload Changes: The following two patient classification workload refinements were approved for implementation in the FY 2001 allocation process.

Since the beginning of the VERA methodology, the Complex Care patient workload has been calculated in part by using a veteran population factor, historical experience, and age. Because the veteran population is declining, and VA market share is increasing, the forecast based on veteran population trends predicts declines in workload numbers when in fact, workloads are rising or remaining somewhat stable overall. Therefore, beginning in FY 2001, the Complex Care projection methodology in VERA was changed to delete the veteran population factor from the calculation. It is now based on historical experience and the impact of age.

Hepatitis C virus infection is now recognized as a serious national problem and is more prevalent in the veteran population. Hepatitis C is a complicated condition that requires a high demand on staff and in cases of active treatment, has a high drug cost. In FY 2001 VERA patient classes for hepatitis C patients were developed at the Basic and Complex Care levels and are based on appropriate diagnosis and active drug therapy.

Geographic Price Adjustment and FY 2000 – FY 2002 Changes in the Adjustment: VERA also recognizes that the national prices do not account for some geographic differences in the cost of providing health care that are not under the control of network and local management. VA examined numerous factors in this regard and determined that an adjustment for the cost of labor was needed. The labor adjustment increases or decreases the network budgets depending on the wages the network must pay its employees in its part of the country. Other factors such as energy costs, age of patients, and cost of drugs were evaluated and found to be insignificant in terms of variance across networks.

For the FY 2000 network allocations the geographic salary adjustment was changed to adopt the labor index methodology recommended by PricewaterhouseCoopers LLP in the *Veterans Equitable Resource Allocation Assessment Final Report.* This methodology differed from the previous methodology in that it used a national market basket approach in the formula to create the index, instead of network level staffing patterns. By using national data, the index formula does not intermingle staffing differences with salary variables. Therefore, the index is generated based upon the specific differences in labor cost.

For the FY 2001 network allocations, the computation of the geographic price adjustment was modified to reflect the resource intensity of Complex Care patients. The adjustment was computed using the personnel salary dollars expended in FY 1999. These salary dollars were used in a formula that accounts for two network-level factors: patients treated and the geographic differences in labor costs. The network-level differences in labor costs are measured by a labor index that quantifies the difference between a network's salary costs and the national average salary costs. In FY 2001, the process for computing the labor index remained the same as in FY 2000, using a standard market basket approach. The adjustment formula, however, was modified to account for the resource intensity of caring for Complex Care patients by weighting Complex Care patients based on their relative cost. Analysis revealed that it is approximately 10 times more costly to care for Complex Care patients as compared to Basic Vested patients. These costs differences are attributed to the more costly staff mix required to care for Complex Care patients.

Two geographic price adjustments were approved for the FY 2002 allocation process to account for local cost of living factors associated with procuring contracted labor and non-labor contracted goods such as energy-related products, utilities and provisions. The existing VERA labor adjustment methodology is now applied to the cost of contracted labor and non-labor goods. These adjustments account for expenses caused by geographic cost factors that are beyond a network's immediate control.

FY 2002 Patient Classification Workload Changes: The following three patient classification workload refinements were implemented in the FY 2002 allocation process.

1. The requirement for having twice as many days in a long term care setting as in an acute care setting to meet the Complex Care pricing group was eliminated. This requirement was designed to encourage minimum acute care days, but now is eliminating otherwise qualifying patients from the Complex Care designation because of their acute stays. Patients requiring both acute and long term care inpatient stays can now qualify for Complex Care without this limiting factor provided that they meet the criteria for at least one Complex Care patient group.

2. The annual bed days of care criteria to qualify for the Complex Care pricing group in long term residential care patient classes changed as follows:

    - The number of care days needed for residential care programs, including Domiciliary, is set at 91 days. Programs such as Compensated Work

Therapy (CWT), Psychiatric Residential and Rehabilitation Treatment Program (PRRTP) will require 91 days as well.

- The number of care days needed for long-term psychiatry is set at 41 days for all major mental health classes. Previously the bed days of care requirement ranged from 60 to 90 bed days of care.
- The Complex Care patient class length of stay criteria for substance abuse will remain unchanged at 180 days.
- The number of care days needed to meet Complex Care criteria for VHA nursing home and intermediate care is fixed at 31 days, regardless of all other acute hospitalization.

3. A new Complex Care class was established for patients actively participating in the Mental Health Intensive Case Management Program (MHICM), with a minimum of 41 visits recorded. Such patients are considered as Chronically Mentally Ill (CMI) patients for future recording and reporting.

Decision Support System (DSS): The DSS was designated as VHA's patient cost assignment system. For this reason, VA uses DSS cost data as the basis for VERA allocations. To transition from the previous Cost Distribution Report to DSS, the VHA Chief Financial Officer established a workgroup to analyze DSS outputs and VERA inputs to ensure an effective transition in the use of DSS to develop future VERA allocations. DSS cost data became the basis for VERA allocations beginning in FY 2002.

VERA Changes Not Approved for FY 2002: There were two additional changes recommended for FY 2002 implementation but which were not approved by the Under Secretary for Health. The first change was to include Priority 7C veterans in the VERA Basic Care patient workload. The second change was to modify the funding allocation split between Basic Care and Complex Care from the FY 1995 split of 62% Basic Care and 38% Complex Care by two percent per year until the fund allocation split equaled the current base year actual cost split.

VERA Results FY 1997 to the FY 2002 Allocation

The results, if the VERA model had been fully applied in FY 1997, demonstrated that resource shifts would range from a loss of 15% to a gain of 16%, as compared to FY 1996 budget allocations. VA believed that such funding shifts could not realistically occur in a single fiscal year. As a result, the funding shifts from VERA have been implemented incrementally. (See Table 15 on page 32)

In FY 1997, VERA was not implemented until April 1, 1997 – halfway through the fiscal year. Therefore, two methods were used to allocate resources in FY 1997. For the first half of the year, the networks were funded at approximately

one half of the FY 1996 level, plus an increase equal to the change in the total systemwide Medical Care appropriation from FY 1996 to FY 1997. This increase was 2.75%. For the months that VERA was used in FY 1997, the maximum amount that any network was reduced was limited to 5% on an annualized basis. When both of these limitations were applied to the VERA methodology, the largest full year reduction (including equipment and non-recurring maintenance) for any network was 1.0% below FY 1996. The largest gain was 6.8% above FY 1996. In FY 1997, 17 networks received more funding than in FY 1996. Twelve of the networks (55%) had increases greater than the total rate of increase in the system's funding from FY 1996 to FY 1997 (i.e., 2.9%). These funding shifts were designed to occur over a three to five-year period to ensure they were effectively managed.

For FY 1998 VERA was used to allocate funds at the beginning of the fiscal year. The amount that any network was reduced below FY 1997 was limited to 5%. Based on the model's results, 13 networks received increases over funding levels for FY 1997; eight networks received less funding.

In addition, Congress enacted provisions in the FY 1998 budget for VA to retain medical collections rather than return them to the Department of Treasury, as had been required in the past. The legislation terminated the Medical Care Cost Recovery (MCCR) Fund and established the Medical Care Collections Fund (MCCF). Since July 1, 1997, all collections from third-party reimbursements, copayments, per diems, and certain torts were deposited in this new fund. Amounts in the MCCF are then transferred to the Medical Care account and will remain available until expended. A total of $647 million was collected in MCCF for FY 1998. In addition, a total of $83 million in other reimbursements was collected in FY 1998. These include reimbursements for sharing and TRICARE. Thus, each network's FY 1998 budget included these reimbursements plus VERA allocations.

In FY 1999, the amount any network was reduced below FY 1998 was limited to 5%. Seven networks received less funding than in FY 1998, while 14 networks received increases. $571 million was collected in MCCF and $98 million was collected in other reimbursements in FY 1999.

For FY 2000, all networks received more funding than in FY 1999. The 5% cap applied in previous years was no longer necessary because no network was reduced more than 5% from its FY 1999 level. Thus, the funding shifts under VERA were completed in FY 2000 as they took place over a four-year period. $573 million was collected in MCCF and $104 million was collected in other reimbursements in FY 2000.

In FY 2001, all networks received increases over funding levels for FY 2000. The FY 2000 VERA funding base was adjusted to reflect the centralized funding of prosthetics for FY 2001. $771 million was collected in MCCF and $120 million was collected in other reimbursements in FY 2001.

For the FY 2002 VERA allocation distributed to the networks, all 21 networks received increases over funding levels for FY 2001. The FY 2001 funding base was adjusted for the rescission and VERA adjustments for FY 2001. $985 million was collected in MCCF and $320 million was collected in other reimbursements in FY 2002.

A major premise of VERA is that if networks receive reduced allocations they will adjust by becoming more efficient - not by reducing services or numbers of veterans served.

VERA Supplemental Adjustments

Table 19 shows the history of VERA Supplemental Adjustments from FY 1999 to FY 2002. From FY 1999 to FY 2001, the initial VERA allocations of the Medical Care appropriation were subsequently adjusted through a supplemental funding process for those networks that required additional funding above their VERA allocation. This supplemental funding adjustment was provided from VHA's National Reserve Fund that is established at the beginning of each fiscal year as part of the Specific Purpose amount to cover unforeseen and unanticipated requirements. In FY 1999, an adjustment of $9 million was required for two networks, 8 and 9. In FY 2000, an adjustment of $90.7 million was required for two networks, 3 and 23. In FY 2001, an adjustment of $220.1 million was required for three networks, 1, 3 and 23. The size of the FY 2001 adjustment combined with an unexpected Congressional rescission of $43 million that occurred after the initial distribution exceeded the amount available in the National Reserve Fund. This resulted in the need to withdraw network funds after the initial allocation to meet the requirements of the supplemental adjustment and the Congressional rescission.

Based on the FY 2001 experience, VHA reengineered the supplemental funding adjustment process in FY 2002 so that these adjustments were executed as part of the initial VERA allocation of the Medical Care appropriation. As part of the reengineered process, a concerted effort was made to develop updated estimates of each network's projected FY 2002 financial status. This included developing estimates of all the resources that would be available to each network and their corresponding estimated expenses for the year. The estimate of available resources included funds carried over from FY 2001, estimated collections, estimated reimbursements, and the estimated VERA allocation of the medical care

appropriation. The estimated FY 2002 expenses were based on the actual expenses of FY 2001, plus approved budget increases for inflation and pay raises, minus a two-percent efficiency target. Based on this analysis, it was determined that four networks should receive an adjustment to their initial VERA allocation. Table 19 provides a summary of the VERA adjustments from FY 1999 through FY 2002.

Table 19: VERA Adjustments FY 1999 - FY 2002
($ in millions)

Network	FY 1999	FY 2000	FY 2001	FY 2002
8 Bay Pines	$4.0			
9 Nashville	$5.0			
3 Bronx		$66.2	$73.8	$135.3
23 Minneapolis		$24.5	$93.0	$76.8
1 Boston			$53.2	$58.7
12 Chicago				$20.8
Total	$9.0	$90.7	$220.1	$291.6
Percent of Total System-Wide Allocation	0.1%	0.5%	1.2%	1.6%

Note: The numbers may not add due to rounding.
The FY 2002 amount for Network 3 includes the $6.8 million February supplemental funding for the World Trade Center disaster. The FY 2002 amount for Network 1 includes the additional August $17.4 million operational shortfall funding adjustment.

In FY 2003, VA refined VERA by implementing a low cap of 5% and a resulting high cap of 12.6% on allocation increases over FY 2002. The purpose of this cap is to eliminate the need for supplemental funding adjustments to networks in FY 2003.

Previous VERA Assessments

GAO Evaluations

In its September 1997 report, *VA Health Care: Resource Allocation Has Improved, but Better Oversight Needed* (GAO/HEHS-97-178), the GAO recognized the impact of VA's progress in implementing VERA. GAO cited that "VERA shows promise for correcting long-standing regional funding imbalances that have impeded veterans' equitable access to services. Specifically, VERA allocates more comparable amounts of resources to the 22 networks for high-priority VA health service users – those with service-connected disabilities, low incomes or special health care needs – than the resource allocation process it has replaced." In its report, GAO made the following two recommendations:

GAO Recommendation 1:
"Develop more timely and detailed indicators of changes in key VERA workload measures and medical care practices to maintain VERA's ability to equitably allocate resources in the future and help ensure that veterans receive the most appropriate care."

VA accomplished several activities to implement the GAO's recommendation. Specifically, a tracking system was developed to monitor Complex Care workload relative to VERA funding allocations. This system compared FY 1996 workload levels to FY 1997 workload levels for all Complex Care workload classes, as defined in VERA. That analysis concluded that for the period in question, Complex Care workload did not change significantly. VA has continued to monitor Complex Care workload tracking on a quarterly basis in FY 1998, FY 1999, FY 2000, FY 2001, FY 2002 and will continue this in FY 2003. Also, VA conducted a review of three-year Basic Care patient single encounter workload by network for each of the three-year periods FY 1993-FY 1995, FY 1994-FY 1996, and FY 1995-FY 1997. Single encounter Basic Care patients comprised about 12.5% to 13% of the Basic Care workload in each of the previously mentioned three-year groups. Virtually all of the single encounter Basic Care patients were outpatient visits. Just over $1 billion was allocated to the single encounter patients for FY 1998 because they were funded at the full Basic Care price. The Complex Care workload analyses and single encounter Basic Care patients' analyses were shared with the 22 networks. In FY 1999, VA established a Basic single outpatient visits patient class and allocated $66 for each patient. Also in FY 1999, VA completed a review of three-year Basic single encounter workload with three-year Basic Non-Vested care for FY 1996-FY 1998. In FY 2000, VA established a Basic Non-Vested patient class instead of the Basic single outpatient visits class and allocated $105 for each patient. During FY 2000, 2001 and FY 2002, VA completed an analysis of the three-year Basic Non-Vested workload as a percent of the total three-year Basic workload. Figure 12 on page 98 shows this analysis for the three-year periods FY 1996-FY 1998, FY 1997-FY 1999, FY 1998-FY 2000, and FY 1999-FY 2001.

VHA's Chief Financial Officer and Chief Information Officer continued their efforts to improve the manner in which VERA's underlying data are reported and retrieved. Additionally, VA had a contractor (Systems Flow Incorporated) evaluate the following components of VERA:

- The accuracy and integrity of secondary data.
- Methods of data collection and analysis.
- Models and methodologies underlying the models.
- Documentation of the models.
- Timeliness of work processes.

As these activities indicated, VA Headquarters continued to monitor the numbers of patients provided care compared to previous years to ensure that access to quality care was not compromised.

> **GAO Recommendation 2:**
> "Improve oversight of VISN's allocations of resources to their facilities by: (1) developing criteria for use in designing VISN resource allocation methodologies; (2) reviewing and improving the resulting methodologies, and (3) monitoring the impact of these methodologies on veterans' equitable access to care."

The Under Secretary for Health issued a VHA Directive in October 1997, establishing that the allocation of resources at all levels within VA should be guided by ten principles that move the organization toward accomplishing its systemwide goals and objectives. These principles must be upheld when networks allocate funds to facilities or programs. While VERA is an effective system for allocating resources at the network level, the VERA methodology is not designed to allocate funds to the facility level. This is because there are significant differences at the facility level that, in the aggregate, are not a factor when allocating at the network level. Among the factors that significantly affect facility-level health care environments are: the size, mission, and locality of local facilities; levels of affiliations with academic institutions; efficiency of operations; proportions of "shared patients;" and patient complexity and case-mix. As a result, the following guiding principles were to be used by networks in providing allocations below the network level for the period FY 1998 – FY 2003. Network allocation systems must:

- Be readily understandable and result in predictable allocations.
- Support high quality health care delivery in the most appropriate setting.
- Support integrated patient-centered operations.
- Provide incentives to ensure continued delivery of appropriate Complex Care.
- Support the goal of improving equitable access to care and ensure appropriate allocation of resources to facilities to meet that goal.
- Provide adequate support for the VA's research and education missions.
- Be consistent with eligibility requirements and priorities.
- Be consistent with the network's strategic plans and initiatives.
- Promote managerial flexibility, (e.g., minimize "earmarking" funds) and innovation.
- Encourage increases in alternative revenue collections.

These principles coupled with the VA Headquarters' review process continue to guide network allocations.

In August 1998, the GAO issued a report, *VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed.* Concerned that some networks would be required to implement significant cost-saving steps to manage within the diminished resources they would receive under VERA and that these networks would reduce veterans' access to care as a result, the Congressional Committees on Appropriations directed GAO to analyze changes in access to care in two networks, Network 3 (Bronx) and Network 4 (Pittsburgh). When VERA was initially implemented in FY 1997, VA projected that Network 3 would lose the highest proportion of resources compared with other networks, and that Network 4 would lose some resources, but the change would be the lowest for any network. As directed, GAO reported on three issues: (1) changes in overall access to care, changes in access to certain specialized services, and a comparison of changes in these networks with VA national data from fiscal years 1995 to 1997; (2) the extent to which VA headquarters is working to allocate resources equitably to facilities within networks; and (3) the adequacy of VA's oversight of changes in access to care. Overall, GAO concluded that VA increased access to care for veterans in Networks 3 and 4 and VA nationally. VA increased access mainly by expanding outpatient services through conversion of inpatient resources for that purpose. This increased the efficiency of VA health care delivery and allowed Networks 3 and 4 to serve more veterans with fewer inflation adjusted dollars under VERA. In its August 1998 report, GAO made the following two recommendations:

> **GAO Recommendation 1:**
> "Develop uniform definitions and institute timely reporting of changes in access to care, including the number and eligibility priority of patients served, waiting times for care, and patient satisfaction for specific services at the network and facility level."

VA is working to improve its information systems so that they will be more useful to network and headquarters management. During the past few years, VA has held Data Summits and one of the items it has specifically addressed is the development of uniform definitions to the extent they are practical. Implementing enrollment beginning October 1, 1998 has allowed reporting service utilization by eligibility category, type of provider and geographic distribution among other demographic variables. There are numerous improvements in timely reporting in areas such as performance and quality that were implemented too late to be included in GAO's report. For example, accessibility to performance measure data, including Priority 1 – 7 and market penetration information, is now on a real time basis. Patient satisfaction surveys and the report to Congress, *Maintaining Capacity to Provide for the Specialized Treatment of Rehabilitative Needs of Disabled Veterans* are completed annually. The national and network planning processes also include plans for ensuring equitable access to care. The FY 2003

VHA Performance Plan includes most of the special care outcome measures as well as reporting of the number and eligibility priority of patients served. These are being used to monitor achievements in patient satisfaction and access issues.

> **GAO Recommendation 2:**
> "Develop criteria for equitably allocating resources to facilities and monitor any improvements in equity of access among and within networks."

The VA philosophy concerning network allocations to facilities is to continue balancing oversight with flexibility. VA does not want to dictate how each network should fulfill its responsibilities. VA believes that this philosophy has been effective in network implementation. Nevertheless, in FY 1999, VA added a criterion in the network allocation principles directive concerning the equity of resource allocations to facilities, but the directive does not prescribe how this should be done. VA continues to allow networks the flexibility they need to meet local needs. The directive was distributed to networks in early FY 1999. Although the GAO report states that headquarters did not review the network allocations methodologies in the past, VA has in fact completed these reviews. VA will continue to review the network allocation plans and methodologies to assure equitable resource allocation within networks. Additionally, VA established a workgroup to evaluate the allocation principles and the networks' allocation processes. Its purpose was to determine if the principles were sufficient as well as to ensure that network allocations to facilities are fair and equitable. The results of this review enabled the sharing among networks of the best practices in network-to-facilities allocations methods. All of the network allocation methods have been described and submitted to Congress in accordance with the requirements of the House Appropriations Committee Report 106-286. VHA's guiding resource allocation principles have been used in providing allocations below the network level for the period FY 1998 – FY 2003. These principles coupled with the VA Headquarters' review process will continue to guide future network allocations.

Private Sector Contractor Evaluations

PricewaterhouseCoopers LLP VERA Assessment

FY 1998 was the first full year for VERA-based allocations, and significant amounts of resources were shifted to networks that were previously under-funded. Therefore, to help ensure that VERA was, and is, a sound basis for allocating health care resources, VA retained a private contractor, PricewaterhouseCoopers LLP, to evaluate whether VERA was sound and was meeting its stated objectives. The assessment evaluated VERA's effectiveness and made recommendations for refining VERA.

In general, the study answered three questions: (1) Are VERA's conceptual underpinnings sound? (2) Are VERA's methodological underpinnings and assumptions underlying the components sound? and, (3) After its first year, is VERA meeting its established objectives? PricewaterhouseCoopers LLP determined the following:

- VERA is ahead of other global budgeting systems across the world. It allocates resources on objective measures of need such as patient volume as compared to other global health care funding systems that are built on historical allocations with periodic adjustments for inflation or politics.

- VERA's conceptual underpinnings are sound. They include: a top-down budgeting system that insures solvency, a funding base that follows patients, the vast majority of funding flows through the model, and a funding flow to networks.

- VERA's methodological underpinnings are fundamentally sound. They are: a data driven, formula-based system that promotes credibility; a model structure that is relatively easy to understand; national prices that ensure standardization; and an allocation method that accounts for local cost variations.

- Overall, VERA is meeting its specified objectives. VERA equitably distributes funds across networks; focuses funding on highest priority veterans; addresses veteran special health care needs; complies with PL 104-204 requirements; has a framework that is predictable and easily understood; aligns management and incentives with best practice; accounts for uncontrollable cost differences across networks; improves accountability for research and education support; and conforms to principles of sound financial management.

PricewaterhouseCoopers LLP also provided seven recommendations to strengthen and refine VERA. The recommendations were classified as either immediate or long-term.

Immediate recommendations, that do not depend on how VERA changes, are: simplify data inputs; revise patient classifications; strengthen data accuracy and accountability; clarify and improve the allocation process timetable, and establish a forum to obtain suggestions.

Those recommendations that would be implemented depending on how VERA changes over time are: implement a strategic enrollment system; revise patient classes; and tie performance measures to the budget.

VA has made much progress on the implementation of the immediate recommendations as follows:

- Simplify data inputs

    1. Equipment – Future allocations will be based solely on patient workload. This change was implemented over a 2-year period beginning in FY 1999. The final phase was implemented with the FY 2000 allocation. This completed the phase-in of 100% of equipment allocations being based on patient workload.

    2. Non-recurring maintenance – Future allocations will be based on patient workload with an adjustment for differences in regional construction costs. This change was implemented over a 3-year period beginning in FY 1999. The third and final phase was implemented with the FY 2001 allocation.

    3. Labor adjustment – Future adjustments would use an index based on a single national market basket for labor. A workgroup evaluated this alternative to the current method. The establishment of a single national market basket for labor was approved and was implemented for the FY 2000 allocation.

- Revise patient classifications and budget split

    1. Patient classification – The patient classification system would be based on diagnosis and functional data. Classifying patients on the basis of diagnostic and functional data using VA DCGs (Diagnostic Cost Groups) instead of utilization characteristics is being evaluated for consideration in FY 2005.

    2. Budget split – The split between Basic Care and Complex Care budgets would be revised to reflect the most recent costs of these two groups of patients. VA does not want to set a national policy that would divert, or appear to divert, resources from its Complex Care patients; therefore, this issue was carefully reviewed before a change was made. This issue was examined within the context of the review of the entire patient classification system. This change was first considered for implementation in the FY 2002 allocation, but action was deferred pending further analysis. In FY 2003, with the expansion of VERA price groups from three to ten, this change also modified the funding allocation split between Basic Care and Complex Care to reflect the current base year cost experience between these groups rather than using a fixed ratio that reflects their FY 1995 relative costs.

- Strengthen data accuracy and accountability

1. In the fall of 1998, the Data Integrity Workgroup was formed and comprises representatives from field facilities, networks, and Headquarters including the Allocation Resource Center and Decision Support System staff. The following components of the VERA allocation process was reviewed for the FY 2003 allocation:

   - Prorated Patients and Cost: This is derived from tracking costs for each patient in the system, and was validated by comparing the total social security numbers in the Allocation Resource Center (ARC) system to those in the VHA Data System in Austin, Texas. Matching allocated patient costs back to the Cost Distribution Report (CDR) validates costs. Each facility is asked to validate that its cost reports are reviewed for completeness and accuracy. Information is published, showing areas of cost reporting and workload that may be inaccurate, to assist facilities throughout the year. A sample also is taken of patient class assignments to ensure accuracy.

     Beginning with the FY 2002 allocation process, the Decision Support System (DSS), was introduced into the process. After adjusting for the full cost factors in DSS that include national, network, and depreciation costs, specific patient cost is used to calculate the share of workload assignment in cases where a patient has been treated in more than one network.

   - Research Support: Three types of research are identified for receiving research support funding allocations: research administered by the VA; research not administered by the VA but peer reviewed; and research not administered by the VA and not peer reviewed. The Headquarters Research and Development Office records the three types of research, and the ARC calculates the allocation. All calculations were reviewed.

   - Education Support: These dollars are distributed based on residency positions as designated by the Office of Academic Affiliations.

   - Non-recurring Maintenance (NRM): In FY 2003, as in FY 2001 and FY 2002, the entire NRM calculation is based on construction cost adjusted patient workload. Construction cost numbers by area of the country is derived from the nationally recognized Boeckh Index. These numbers are applied to each VA-owned medical center property. All calculations were verified as correct.

- Equipment: These dollars are distributed based on patient workload, and calculations have been verified.

- Geographic Price Adjustment (Labor Index): VA bases this adjustment on the variance in labor costs in different parts of the country. An index that compares network cost with national cost is created. The geographic price adjustment is first computed using actual salary dollars expended in FY 2001, weighted workload, and the network labor index. All calculations have been thoroughly reviewed. Starting in FY 2001, VA approved a change in the geographic price adjustment calculation to reflect the resource intensity of caring for Complex Care patients. Complex Care patients are weighted to reflect the costs of caring for these patients. Weighting factors were derived from FY 2001 cost data.

  The VERA 2002 model was modified to include a new adjustment that adjusts for funding inequities caused by local procurement practices for contracted goods and services including: labor; service agreements; and locally purchased energy-related products, utilities, and provisions. These network-level purchases are subject to regional price variations resulting from local cost of living factors. The VERA model now contains an adjustment that compensates high-cost networks for these expenditures. The adjustment is computed using the model's labor adjustment methodology, which is calculated and validated each year. The primary adjustment factor is the VHA labor index, which is derived from VHA staff salaries. The VHA labor index adjusts allocations associated with regional variations in costs.

2. Standardize procedure for field review of data outputs – The data integrity workgroup also implemented a procedure for field review of data output. This process started in FY 1999 and continues in FY 2003.

- Clarify and improve process

1. Improve allocation process timetable – VA has increased efforts to speed the data closeout and input data to the allocation system. This improved the FY 1999, FY 2000, FY 2001, and FY 2002 allocation timetables by nearly two months, thereby giving the field more time to plan their budgets as well as to review the data on which they were based. Preliminary FY 2003 planning allocations based on the President's budget were issued to the networks in February 2002, less than five months after the end of FY 2001.

2. Use a suggestion box – A suggestion box has been established and is accessible through the Allocation Resource Center website.

VA also has begun to implement the long-term recommendations of PricewaterhouseCoopers LLP in anticipation that some future changes will be made to VERA. The status of these recommendations is listed as follows.

- Implement a strategic enrollment system

    1. Develop a strategy-based enrollment system – VA implemented an enrollment system in FY 1999, as required by law. It was determined that VERA allocations based on enrollment may not be the most equitable distribution of resources because all of those enrolled may not use VA services.

    2. Implement a transfer pricing system – A recommendation for implementing a transfer pricing system in FY 1999, but not actually transferring funds, was approved by the Under Secretary for Health. The Care Across Network workgroup was charged with planning the implementation of transfer pricing. VA tested the proposed transfer pricing system in FY 2000 to help determine the benefits of implementing a transfer pricing program. A recommendation by the Care Across Networks Workgroup not to proceed with transfer pricing in FY 2001 was approved by VA in March 2000. Key issues that were responsible for not implementing transfer pricing included: impact on improving coordination of care; whether level of effort is worth the benefit; and technical and software challenges to implement. VA will continue to use the existing pro rated person (PRP) concept to ensure that the care across networks is compensated.

- Revise patient classes

    1. For the FY 1999 allocation an additional patient class was created within the basic care group that included the lowest cost patients. This issue was refined for the FY 2000 allocation. VA's goal was to determine what constitutes a fully vested patient, even with one visit, and fund those patients at the Basic Vested Care price. As a result, VHA decided that Basic Care patients will now consist of two groups, fully vested and non-vested patients. In addition, VHA approved nine other refinements to the VERA patient classifications that were implemented in FY 2000, two that were implemented in FY 2001, and three refinements for the FY 2002 allocation process.

    2. In FY 2003, the VERA price groups expanded from three to ten to recognize a differentiation in VA's "core mission" patients (veterans with service-connected disabilities or those with incomes below the current

threshold or special needs patients, e.g., the homeless) not present in the three VERA price groups.

3. The VHA National Leadership Board Finance Committee will determine if additional patient class changes are needed for future years.

- Tie performance measures to budget

1. Use rewards based on performance using reasonable and effective incentives – This would require that both the VERA and the performance measure systems are mature and stable enough to support a direct link to budget allocations. This would also involve significant policy issues regarding the purpose of VERA (to fund veterans' health care needs) and, the purpose of performance measures. As of FY 2003, the VERA methodology and performance measures remain as separate systems.

AMA Systems, Inc. – Evaluation of Patient Health Status by VISN

VERA adjusts for the differences across networks for high cost patients and patients in need of specialized services by providing a higher price for Complex Care patients as compared to the prices for Basic Vested Care and Basic Non-Vested Care patients. Nevertheless, feedback from internal and external stakeholders indicated that they believe VERA may not adequately distinguish the differences across networks for variances in patient health status.

VHA retained AMA Systems, Inc. and its subcontractor, The Center for Naval Analyses Corporation (CNAC) to conduct a study entitled "Evaluation of Patient Health Status by VISN." The scope of the analysis was later expanded to include research into costs associated with providing VHA health care in rural areas to satisfy Section 108 of Public Law 106-74, the "Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2000." The report, "Evaluation of Rural Healthcare in the 22 Veterans Integrated Service Networks" was provided to Congress on April 25, 2000.

The following tasks were included in the contractor's scope of work:

- Determine whether the health status of VHA patients varies across the 22 Veterans Integrated Service Networks (VISNs) and whether such differences have an adverse impact on distribution of funds as provided for by the VERA system.
- If the proportion of high-cost patients varies across the VISNs, determine whether the variance is the result of inefficiencies in resource management or differences in patient health status.

- Determine whether practice patterns and infrastructure (e.g., physical plant) affect healthcare costs.
- If cost variances exist because of differences in patient health status and other factors, identify the relative contribution to cost variances of patient health status and these other factors.

The contractor reviewed VERA, analyzed more than ten million individual patient records for the period FY 1997 through FY 1999, and conducted site visits at medical centers and VISN offices. On the basis of this data collection and preliminary analysis, it developed a quantitative model to assess the cost contribution of various factors (e.g., case-mix, age, practice patterns). In addition, the contractor examined the issue of whether developing additional price categories for the Complex and Basic patient groups would provide a "better fit" in terms of matching patient group prices with actual VHA cost profiles.

The report concluded the following with regard to patient health status:

- Systematic influences affect the deviation of VISN-level average costs from the overall national average; these costs are not completely captured by VERA formulation.
- Five separate and statistically significant patient characteristics influence the deviation in average cost for each VISN compared to the national average: age, case-mix index, proportion of patients in the Community Nursing Home category, proportion of patients in the fee for service category, and the proportion of patients that are female.
- Age of patients is considered in the current rates in VERA, but in a linear fashion. The impact of age is non-linear, and becomes increasingly important at the upper end of the age distribution (i.e., above age 75).
- Two infrastructure characteristics influence the deviation in average cost: total VA beds and the ratio of direct VA staff to indirect VA staff.
- The contractor's model explains 70 percent of the deviation in cost. Other influences on the deviation may exist.
- There was no statistically significant difference due to practice patterns.
- At the VISN level, the additions to and subtractions from average cost may cancel each other. As a result, without additional study, it is impossible to identify specific modifications that would be appropriate to make to the current VERA formulation. However, the contractor's model can be used to evaluate the relative predicted funding across VISNs, and to verify if VERA gives results similar to the predictions. Such comparisons must be done with care, as VERA funding does not map perfectly to patient-level costs used to build the model.

- Expanding the number of VERA patient groups and reimbursing at the national price levels does not yield sufficient additional precision to merit serious consideration by VHA.

AMA Systems, Inc. submitted a final report to VA on July 25, 2000. This study was widely shared by VA both internally and externally and included, Network Directors, VHA Headquarters Chief Officers, VERA Workgroups and Congress for information purposes. The VERA Workgroups were asked to review it to determine if adjustments to the VERA model were needed to ensure resources continue to be equitably allocated throughout the country.

The reports', "Evaluation of Patient Health Status by VISN" and "Evaluation of Rural Health Care in the 22 Veterans Integrated Service Networks", four recommendations for further study include:

- A study to determine the precise way to implement funding modifications because it is not immediately clear how the contractor's model information can or should translate into VERA modifications.
- A comparison of predicted costs for each VISN to actual funding allocations that can identify VISNs with funding misallocations.
- A study to determine if rural patients receive the same level of care and if their outcomes are similar to what is observed for urban patients.
- The report suggested that more knowledge about veterans who are enrolled and those eligible to use the system but not enrolled is needed. In addition, it suggested a survey to assess veterans' income, availability and preferences for health care, and access to alternate insurance coverage.

The VHA Office of Finance asked VHA's Office of Quality and Performance and Office of Policy and Planning to review the latter two of the reports' four recommendations above to determine follow-up action:

The VHA Office of Policy and Planning responded that the survey proposed in the last recommendation above would be duplicative of four surveys listed below that provide that information, and therefore no further action was required.

1. The 1999 Survey of Veterans Enrollees' Health and Reliance Upon VA
2. The 2000 Survey of Veterans Enrollees' Health and Reliance Upon VA
3. The National Survey of Veterans
4. The 1999 Health Survey of Enrollees (Veterans SF-36 and Health Behaviors)

AMA Systems, Inc. – Evaluation of Rural Health Care in the 22 Veterans Integrated Service Networks

As a result of increasing concerns from a number of stakeholders, VA amended its evaluation of patient health status contract study to include an analysis of the efficiency of resource allocation to rural areas within the VERA process. The contractor reviewed the differences in costs for care across the VHA's 22 networks due to provision of care in rural settings. The contractor visited seven sites identified as rural areas throughout the country to attain the findings. The sites visited were: Northampton, Massachusetts; Togus, Maine; Grand Island, Lincoln and Omaha, Nebraska; Fort Harrison, Montana; and Vancouver, Washington. The project time constraints limited the contractor's ability to visit all networks. The contractor used an Office of Management and Budget approved rural-urban index. The report concluded the following with regard to rural health care:

- Rural veteran patient distribution by VISN varies across the country.
- Statistically significant factors that influenced the report's regression model were patient characteristics and infrastructure.
- It was not possible to detect the independent impact of the variables for rural health care and practice patterns due to the limited amount of historical data for analysis.
- None of the sites maintained systematic records of distance that veterans travel to receive health care.
- None of the sites maintained systematic records of waiting times for appointments. It should be noted that VA recently implemented a new methodology to measure waiting times as part of the service and access initiative. GAO indicated they are satisfied with the new methodology.
- The rural variable decomposed into two variables, rural and very rural. Six networks were deemed rural (6, 7, 9, 16, 18, and 19) and three networks were deemed very rural (13, 14, and 15).
- Providing care in rural areas is less costly than providing care in urban areas.
- Providing care in very rural areas is more costly than providing care in urban areas.

The information provided during site interviews was anecdotal and based on staff perceptions and hands-on experiences. Only selected sites were visited, thus the findings are more illustrative than definitive of issues that may impact VA health care. These issues included:

- Staffs indicated some population segments utilize more resources than others, but there was no consistent pattern from site to site.

- Private practice patterns impact how VA provides services. Staff at rural sites noted concerns about the difficulty in establishing community based outpatient clinics (CBOCs) due to inability to hire or convince staff to move; lack of private providers in Western rural areas; and some private providers' refusal to compete to operate CBOCs.
- Staff stated transportation costs are higher in rural areas than urban.
- In reviewed sites, the report noted the extreme distance and amount of time it could take a veteran to travel to a major VISN facility if they lived at the far edge of the region. It also noted no systematic records of patient travel time or distances. However, it contains VA's analysis of average and maximum straight-line distances between zip codes.
- An indication that rural areas rely more on fee-for-service arrangements for patients who do not live within reasonable proximity of VA facility.

AMA Systems, Inc. submitted a rural report to VA on March 1, 2000. VA provided this study to Congress per legislative requirements and shared it with Headquarters Chief Officers, Network Directors, and the VERA Workgroups. Workgroups were asked to review it to determine if adjustments to the VERA model are needed to ensure that resources continue to be equitably allocated to rural and urban areas throughout the country. As a result of this review, it was determined that no adjustments to the VERA model were required. VHA anticipates, through the Network to Facilities allocation processes, that those networks having the highest number of rural patients will receive their fair share of resources.

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